DOCKET

SUPREME COURT
OF THE UNITED STATES

No. 09-1233
Vide 09-1232
Title: Edmund G. Brown, Jr., Governor of California, et al., Appellants
v.
Marciano Plata, et al.
Docketed: April 14, 2010
Linked with 09A849
Lower Ct: United States District Courts for the Eastern District and the Northern District of California
Case Nos.: (CIV S-90-0520 LKK JFM P, C01-1351 TEH)
Decision Date: January 12, 2010
Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~~
Jan 22 2010	Docket Sheet received from U.S.D.C. for Northern District of California. (1 envelope)
Mar 11 2010	Application (09A849) to extend the time to file a jurisdictional statement on appeal from March 20, 2010 to April 12, 2010, submitted to Justice Kennedy.
Mar 15 2010	Application (09A849) granted by Justice Kennedy extending the time to file until April 12, 2010.
Apr 12 2010	Statement as to jurisdiction filed. (Response due May 14, 2010)
May 14 2010	Motion to dismiss or affirm filed by Coleman Plaintiffs-Appellees. VIDED.
May 14 2010	Motion to dismiss or affirm filed by Plata Appellees. VIDED.
May 14 2010	Motion to dismiss or affirm filed by appellee Intervenor California Correctional Peace Officers' Association. VIDED.
May 24 2010	Consolidated opposition of appellants to appellees' motions to dismiss or affirm filed. (Distributed)
May 25 2010	DISTRIBUTED for Conference of June 10, 2010.
Jun 14 2010	Further consideration of the question of jurisdiction is POSTPONED to the hearing of the case on the merits.
Jul 2 2010	The Clerk has approved use of the deferred joint appendix method.
Jul 6 2010	The time to file appellants' brief on the merits is extended to and including August 27, 2010.
Jul 6 2010	The time to file appellees' briefs on the merits is extended to and including October 25, 2010.
Jul 6 2010	Counsel for the appellants agrees to file a reply brief on the merits, if any, on or before November 19, 2010.
Jul 21 2010	Consent to the filing of amicus briefs, in support of either party or of neither party, received from counsel for appellees, counsel for the appellants, and counsel for appellee intervenor.
Aug 24 2010	Record received from U.S.D.C. for Northern District of California (7 boxes). There are sealed documents in this record.
Aug 25 2010	Record received from U.S.D.C. for Eastern District of California. (22 boxes)
Aug 27 2010	Brief of appellees California State Republican Legislator Intervenors, et al. filed.
Aug 27 2010	Brief of appellants Arnold Schwarzenegger, Governor of California, et al. filed.
Sep 3 2010	Brief amici curiae of Louisiana, et al. filed.
Sep 3 2010	Brief amicus curiae of Greater Stockton Chamber of Commerce filed.
Sep 3 2010	Brief amicus curiae of Criminal Justice Legal Foundation filed.
Sep 7 2010	SET FOR ARGUMENT ON Tuesday, November 30, 2010.
Sep 27 2010	CIRCULATED
Oct 25 2010	Brief of Coleman Appellees filed. (Distributed)
Oct 25 2010	Brief of Appellee Intervenor California Correctional Peace Officers filed.

	(Distributed)
Oct 25 2010	Brief of Plata Appellees filed. (Distributed)
Oct 26 2010	Trial exhibits received from counsel. (There are sealed documents in these exhibits)
Oct 29 2010	Brief amici curiae of American Civil Liberties Union, et al. filed. (Distributed)
Nov 1 2010	Brief amici curiae of American Psychiatric Association, et al. filed. (Distributed)
Nov 1 2010	Motion for leave to file amici brief out of time filed by J. Clark Kelso, Receiver for Medical Healthcare for the California State Prisons
Nov 1 2010	Brief amicus curiae of American Bar Association filed. (Distributed)
Nov 1 2010	Brief amici curiae of Prison Fellowship, et al. filed. (Distributed)
Nov 1 2010	Brief amici curiae of Center on the Administration of Criminal Law and 30 Criminologists filed. (Distributed)
Nov 1 2010	Joint motion of appellees for divided argument filed.
Nov 1 2010	Brief amici curiae of American Public Health Association, et al. filed. (Distributed)
Nov 1 2010	Brief amici curiae of Corrections and Law Enforcement Personnel filed. (Distributed)
Nov 8 2010	Joint appendix filed (6 volumes). Statement of costs filed. (Distributed)
Nov 10 2010	Application (10A483) of appellants for leave to file a reply brief on the merits in excess of the word limit, submitted to Justice Kennedy.
Nov 12 2010	Application (10A483) of appellants for leave to file a reply brief on the merits in excess of the word limit granted by Justice Kennedy.
Nov 15 2010	Motion of appellees for divided argument DENIED. An additional ten minutes are allotted to each side for oral argument.
Nov 19 2010	Reply of appellants Arnold Schwarzenegger, Governor of California, et al. filed. (Distributed)
Nov 19 2010	Reply of Intervenors filed. (Distributed)
Nov 23 2010	Motion for leave to file amicus brief out of time filed by J. Clark Kelso, Receiver for Medical Healthcare for the California State Prisons GRANTED.
Nov 30 2010	Argued. For appellants: Carter G. Phillips, Washington, D. C. For appellees: Donald Specter, Berkeley, Cal.

JURISDICTIONAL STATEMENT

B101

No. 09-1 001233

FILED

APR 12 2010

OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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QUESTIONS PRESENTED

1. Whether the three-judge district court had jurisdiction to issue a "prisoner release order" pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626.

2. Whether the court below properly interpreted and applied Section 3626(a)(3)(E), which requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right; and ... no other relief will remedy the violation of the Federal right" in order to issue a "prisoner release order."

3. Whether the three-judge court's "prisoner release order," which was entered to address the allegedly unconstitutional delivery of medical and mental health care to two classes of California inmates, but mandates a system-wide population cap within two years that will require a population reduction of approximately 46,000 inmates, satisfies the PLRA's nexus and narrow tailoring requirements while giving sufficient weight to potential adverse effects on public safety and the State's operation of its criminal justice system.

PARTIES TO THE PROCEEDING

Appellees are the following:

Gilbert Aviles
Steven Bautista
Ralph Coleman
Paul Decasas
Raymond Johns
Joseph Long
Clifford Myelle
Marciano Plata
Leslie Rhoades
Otis Shaw
Ray Stoderd

Intervenor-plaintiff:

California Correctional Peace Officers' Association,

Appellants are the following five defendants:

Governor Arnold Schwarzenegger
Matthew Cate, Secretary of the California Department of Corrections and Rehabilitation
John Chiang, California State Controller
Ana J. Matosantos, Director of the California Department of Finance
Stephen W. Mayberg, Director of the Department of Mental Health

The following 144 individuals are intervenor-defendants:

Samuel Aanestad, Legislator
Anthony Adams, Legislator
Amador County Sheriff Martin Ryan
Joel Anderson, Legislator
Roy Ashburn, Legislator
Chief Probation Officer Kim Barrett

James F. Battin, Jr.*, Legislator
Tom Berryhill, Legislator
Sam Blakeslee, Legislator
Police Chief Michael Billdt
Butte County Chief Probation Officer John Wardell
Butte County Sheriff-Coroner Perry L. Reniff
Calaveras County Sheriff Dennis Downum
District Attorney Ronald L. Calhoun
Chief Probation Officer Lionel Chatman
City of Alhambra Police Chief Jim Hudson
City of Atwater Police Chief Richard Hawthorne
City of Delano Chief of Corrections George Galaza
City of Delano Police Chief Mark DeRosia
City of Fremont Police Chief Craig Steckler
City of Fresno Police Chief Jerry Dyer
City of Grover Beach Police Chief Jim Copsey
City of Modesto Police Chief Roy Wasden
City of Pasadena Police Chief Barney Melekian
City of Paso Robles Police Chief Lisa Solomon
City of Roseville Police Chief Joel Neves
City of San Bernardino Police Chief Michael Billdt
City of Santa Clara Police Chief Steve Lodge
City of Sonora Police Chief Mace McIntosh
City of Vacaville Police Chief Rich Word
City of Whittier Police Chief Dave Singer

City of Woodland Police Chief Carey Sullivan
District Attorney Gregg Cohen
Contra Costa County Chief Probation Officer Lionel Chatman
Contra Costa County Sheriff Warren Rupf
County of San Mateo
County of Santa Barbara
County of Santa Clara
County of Solano
County of Sonoma
Paul Cook, Legislator
Dave Cox, Legislator
Police Chief Mark DeRosia
Chuck DeVore, Legislator
Del Norte County Sheriff Dean Wilson
Sutter County Sheriff Jim Denney
District Attorney Bonnie M. Dumanis
Robert Dutton, Legislator
Michael D. Duvall, Legislator
El Dorado County Sheriff Jeff Neves
Bill Emmerson, Legislator
District Attorney Bradford Fenocchio
Fresno County Chief Probation Officer Linda Penner
Fresno County Sheriff Margaret Mims
Jean Fuller, Legislator
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National City Police Chief Adolfo Gonzales
Ted Gaines, Legislator
Martin Garrick, Legislator
Police Chief Richard Hawthorne
Sheriff Pat Hedges
Dennis Hollingsworth, Legislator
Shirley Horton*, Legislator
Guy S. Houston*, Legislator
Police Chief Jim Hudson
Bob Huff, Legislator
Humboldt County Sheriff Gary Philip

Inyo County Chief Probation Officer Jim Moffet
Inyo County Sheriff William Lutze
District Attorney Edward R. Jagels
Kevin Jeffries, Legislator
Sheriff Larry Jones
Sheriff Mike Kanalakis
Rick Keene*, Legislator
Kern County Sheriff Donny Youngblood
District Attorney Robert Kochly
Doug La Malfa*, Legislator
Bill Maze*, Legislator
Lake County Sheriff Rod Mitchell
Lassen County Sheriff Steve Warren
Los Angeles County Sheriff Lee Baca
Sheriff William Lutz
Abel Maldonado, Legislator
Mariposa County Chief Probation Officer Gail Neal
Sheriff Jim Mele
Police Chief Barney Melekian
Mendocino County Sheriff Tom Allman
Merced County Sheriff Mark Pazin
Chief Probation Officer Don Meyer
Chief Probation Officer Jim Moffett
Mono County Sheriff Richard Scholl
Monterey County Sheriff Mike Kanalakis
San Joaquin County Sheriff Steve Moore
District Attorney Clifford Newell
Roger Niello, Legislator
Orange County Sheriff Coroner Michael S. Carona
District Attorney Rod Pacheco
District Attorney David W. Paulson
District Attorney Vern Pierson
Placer County Sheriff Edward N. Bonner
District Attorney John R. Poyner
District Attorney Tony Rackauckas
District Attorney Michael Ramos

District Attorney Michael Ramsey
Chief Probation Officer Brian Richart
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Riverside County Sheriff Bob G. Doyle
George Runner, Legislator
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San Diego County Sheriff William B. Kolender
San Mateo County Sheriff Greg Munks
Santa Barbara County Chief Probation Officer Patricia Stewart
Santa Barbara County Sheriff Bill Brown
Santa Clara County Sheriff Laurie Smith
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Jim Silva, Legislator
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Sonoma County Chief Probation Officer Robert Ochs
Sonoma County District Attorney Stephan Passalacqua
Sonoma County Sheriff/Coroner William Cogbill
Todd Spitzer*, Legislator
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Stanislaus County Sheriff Adam Christianson

Stanislaus County Sheriff's Department
District Attorney Christie Stanley
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Audra Strickland, Legislator
District Attorney Gregory Totten
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Ventura County Sheriff Bob Brooks
Michael N. Villines, Legislator
Mimi Walters, Legislator
Police Chief Rich Word
Mark Wyland, Legislator
Yolo County Sheriff Ed Prieto
Yuba County Sheriff Steve Durfor
Bill Berryhill, Legislator
Connie Conway, Legislator
Danny Gilmore, Legislator
Curt Hagman, Legislator
Diane Harkey, Legislator
Steven Knight, Legislator
Dan Logue, Legislator
Jeff Miller, Legislator
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Jim Nielsen, Legislator

* No longer in the Legislature

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OPINIONS BELOW

On January 12, 2010, the three-judge district court (Reinhardt, Henderson, Karlton, J.J.) entered the "Order to Reduce Prison Population" (App. 1a-10a) that is the subject of this appeal. See 2010 WL 99000. On August 4, 2009, the three-judge court made the predicate findings for the order on appeal. See 2009 WL 2430820, reproduced in the Appendix to the Jurisdictional Statement filed in No. 09-416 at 1a-256a.[1] The *Coleman* court's January 4, 2010 order (App. 11a-16a) is available at 2010 WL 55886.

The three-judge court's order denying the State's motion to dismiss or, in the alternative, for summary judgment (09-416-App. 257a-272a) is available at 2008 WL 4813371. The orders granting plaintiffs' motions to convene a three-judge court (09-416-App. 273a-304a) are available at 2007 WL 2122657 and 2007 WL 2122636.

JURISDICTION

On July 23, 2007, over the objections of appellants ("the State"), the District Courts for the Northern and Eastern Districts of California entered orders convening a three-judge district court pursuant to the PLRA, 18 U.S.C. § 3626(a)(3)(B), in accordance with 28 U.S.C. § 2284. 09-416-App. 273a-304a. The State contends that the three-judge court was improperly convened and lacked jurisdiction to issue the order on appeal. *Infra* 11-18.

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[1] The Clerk of Court authorized the parties to cite the appendices filed in Number 09-416 rather than reproducing those materials. Appellants cite that appendix as "09-416-App." and this Jurisdictional Statement's Appendix as "App."

On January 12, 2010, the three-judge court's "Order to Reduce Prison Population" granted injunctive relief under the PLRA. App. 1a-10a. The State noticed its appeal on January 19, 2010. App. 17a-24a. This Court has jurisdiction under 28 U.S.C. § 1253.

STATUTORY PROVISIONS INVOLVED

The PLRA's relevant provisions, 18 U.S.C. § 3626, are reproduced at 71a-73a.

STATEMENT OF THE CASE

Pursuant to the PLRA, the three-judge district court issued an "Order to Reduce Prison Population," *i.e.*, a "prisoner release order." 18 U.S.C. § 3626(a)(3). Although that court *sua sponte* stayed the order pending resolution of this appeal, once it takes effect, the State must cap its aggregate prison population at 137.5% of the institutions' combined design capacity within two years to address allegedly unconstitutional medical and mental health care provided to two plaintiff-classes of California inmates. Ultimately, the court has required the State to reduce the population of its correctional facilities by approximately 46,000 inmates.[2] This is the first PLRA "prisoner release order" imposed over a defendant's objection and the most sweeping intrusion into a state's management of its correctional facilities in history.

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[2] The three-judge court estimated the required prisoner reduction at approximately 46,000 inmates. 09-416-App. 235a. Appellants use that figure for simplicity although the prison population—and thus the necessary reduction—fluctuates over time.

This appeal presents substantial questions concerning the availability and scope of "prisoner release orders" under the PLRA. Before Congress enacted the PLRA, this Court had repeatedly instructed lower courts to exercise extreme caution in using their equitable powers to interfere with the management of prisons, particularly state instituteions. See, *e.g.*, *Lewis* v. *Casey*, 518 U.S. 343, 362-63 (1996); *Preiser* v. *Rodriguez*, 411 U.S. 475, 491-92 (1973). Lower courts recognized that ordering the political branches to release prisoners or cap their prison populations was the most intrusive form of interference. See, *e.g.*, *Inmates of Occoquan* v. *Barry*, 844 F.2d 828, 843-44 (D.C. Cir. 1988). Congress nevertheless concluded that further constraints on federal courts were necessary and enacted the PLRA.

Among other things, the PLRA permits only three-judge courts to issue "prisoner release orders," and such courts may not be convened until certain jurisdictional prerequisites are satisfied. Additionally, three-judge courts shall not order a "prisoner release" unless plaintiffs present "clear and convincing" proof that "crowding" is the "primary cause" of a violation of federal rights and that "no other relief" will remedy the violation. Finally, any "prisoner release order" is circumscribed by strict nexus and narrow tailoring requirements.

This Court's full review of the questions presented here is essential to the orderly development of law under the PLRA. This Court has exclusive jurisdiction over appeals from "prisoner release orders." Thus, any summary affirmance would give the three-judge court's order substantial, unwarranted influence. The decision below conflicts with Congress's design in the PLRA and this Court's prison-conditions and federalism jurisprudence. Probable jurisdiction should be noted.

A. Statutory Background

The PLRA, Pub. L. No. 104-134, tit. VIII, 110 Stat. 1321, 1321-66 (1996), defines the federal courts' remedial powers over conditions of confinement. 18 U.S.C. § 3626. Prospective relief must be "narrowly drawn, extend[] no further than necessary to correct the violation of the Federal right, and [be] the least intrusive means necessary." *Id.* § 3626(a)(1)(A). In considering whether such relief is appropriate, a court "shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." *Id.*

In addition to these constraints, Congress imposed limits on a federal court's ability to enter a "prisoner release order"—*i.e.*, "any order ... that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or non-admission of prisoners to a prison," *id.* § 3626(g)(4)—as a remedy. *Id.* § 3626(a)(3). Only a three-judge district court may grant prisoner release. *Id.* § 3626(a)(3)(C). A three-judge court cannot be convened to consider prisoner release:

> unless—(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and (ii) the defendant has had a reasonable amount of time to comply with the previous court orders.

Id. § 3626(a)(3)(A). Finally, a three-judge court with jurisdiction "shall enter a prisoner release order only if the court finds by clear and convincing evidence that—(i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation of the Federal right." *Id.* § 3626(a)(3)(E).

B. Factual Background

1. The appeal involves two class actions, *Plata* v. *Schwarzenegger* and *Coleman* v. *Schwarzenegger*, and allegations of unconstitutional prison healthcare conditions. *Plata* concerns whether healthcare provided to adult inmates with "serious medical conditions" violates the Eighth Amendment. *Coleman* involves allegations that the mental health care provided to inmates with serious mental disorders violates the Eighth Amendment.

In *Plata*, following settlement of plaintiffs' claims, Judge Henderson approved a stipulation for injunctive relief. *Plata* v. *Davis*, No. C01-1351-TEH (N.D. Cal. June 13, 2002) (D.E. 68).[3] In October 2005, after years of remedial efforts designed "'to provide only the minimum level of medical care required under the Eighth Amendment,'" 09-416-App. 16a, the court concluded that the prison medical system did not meet constitutional standards, *id.* at 14a. It therefore placed the medical health-care delivery system of the California Department of Corrections and Rehabilitation ("CDCR") into Receivership. *Id.* The court concluded that "'[d]espite the best efforts of [the State],'" *id.* at 22a,

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[3] Hereafter, appellants cite orders and other materials from the district court records in *Plata*, No. C01-1351-TEH (N.D. Cal.), and *Coleman*, No. CIV-S-90-0520-LKK (E.D. Cal.), by docket entry number, *i.e.*, "*Plata* D.E. __" and "*Coleman* D.E. __." Although the three-judge court's records typically appear on both dockets, appellants reference only one docket entry for the three-judge court materials. Trial transcripts are cited as "Tr."

inter alia, inmates lacked access to care and specialty services, and that CDCR had "serious personnel problems," "was incapable of recruiting qualified personnel," "lacked medical leadership" and necessary equipment, had not implemented tracking systems for inmates needing chronic care, and had "'a culture of non-accountability and non-professionalism.'" *Id.* at 27a-28a.

The Receiver's appointment was effective on April 17, 2006. 09-416-App. 29a-30a. Just months later, however, plaintiffs moved to convene a three-judge court to consider a "prisoner release order." *Plata* D.E. 561 (filed Nov. 13, 2006).

In *Coleman*, following a 1994 trial, the district court concluded that the mental health care provided to the class violated the Eighth Amendment. 09-416-App. 31a, 33a-35a. In December 1995, the court appointed a special master to oversee implementation of injunctive relief. *Id.* at 36a. In 1997, the court approved plans developed by the Special Master, and in the following years, "defendants continued to work with the Special Master to implement and revise" those plans. *Id.* at 37a. In March 2006, the court approved revised plans. *Id.* at 37a-38a. Eight months later, the *Coleman* plaintiffs moved to convene a three-judge court. *Id.* at 304a.

2. The single-judge courts granted plaintiffs' motions to convene a three-judge court over the State's objections. See 09-416-App. 273a-304a.[4] Judges Henderson and Karlton recommended that the cases be heard by the same three-judge court. *Id.*

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[4] The Ninth Circuit dismissed appeals from the orders convening the three-judge court for lack of jurisdiction. *Coleman* v. *Schwarzenegger*, No. 07-16361, 2007 WL 2669591, at *1 (9th Cir. Sept. 11, 2007) (per curiam).

at 286a, 304a. Then-Chief Judge Schroeder assented, seating Judge Reinhardt to complete the panel. Slip op. at 1 (July 26, 2007) (*Coleman* D.E. 2328).

The State moved to dismiss the three-judge proceedings for lack of jurisdiction and, in the alternative, for summary judgment. On November 3, 2008, the three-judge court denied the motion. 09-416-App. 272a.

Trial was held between November 2008 and February 2009. During trial, the three-judge court prohibited defendants from introducing evidence "relevant only to determining whether the constitutional violations found by the *Plata* and *Coleman* courts were 'current and ongoing.'" 09-416-App. 78a n.42. Moreover, it prohibited the State from obtaining discovery from the Receiver or the Special Master, or from calling them as witnesses. See Slip op. at 3 (Sept. 5, 2008) (*Plata* D.E. 1450); Slip op. at 1-2 (June 5, 2008) (*Plata* D.E. 1226); Slip op. at 1-4 (Nov. 29, 2007) (*Plata* D.E. 988). Additionally, the State lacked a meaningful opportunity before trial to implement Assembly Bill 900 ("AB 900"), which became law in 2007 and authorizes, *inter alia*, $8 billion for construction of correctional facilities. See 09-416-App. 146a-150a.

After trial, the court concluded that crowding was the "primary cause" of the alleged violations of plaintiffs' rights and that no other relief could remedy the violations. See 09-416-App. 78a-165a; *id.* at 126a n.55. The court imposed a "prisoner release order" mandating that the population of California's prisons be capped at 137.5% of their combined design capacity within two years. *Id.* at 169a.

The court concluded that a "prisoner release order" was appropriate notwithstanding its findings that other causes for the alleged constitutional violations exist and that the population cap would *not* remedy them. 09-416-App. 134a, 143a. The court found that the cap satisfied the PLRA's narrow tailoring and nexus requirements, and stated that it gave "substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." 18 U.S.C. § 3626(a)(1)(A); see 09-416-App. 185a-255a.

The court reached these conclusions despite its recognition that the relief "extends further than the identified constitutional violations" and "is likely to affect inmates without medical conditions or serious mental illnesses." 09-416-App. 172a. It selected the 137.5% figure solely because it was "halfway between the cap requested by plaintiffs and the wardens' estimate of the California prison system's maximum operable capacity absent consideration of the need for medical and mental health care." *Id.* at 184a. Additionally, the court acknowledged evidence that, absent effective rehabilitation programs, a prisoner release of this magnitude is likely to cause a statistically significant increase in crime. *Id.* at 241a-248a.

3. The August 4, 2009 order required the State to submit, by September 18, 2009, a plan for meeting the 137.5% cap within two years. 09-416-App. 255a, 235a. The State timely noticed its appeal of the order, *id.* at 354a-355a, and unsuccessfully sought a stay from this Court. *Schwarzenegger* v. *Coleman*, 130 S. Ct. 46 (2009). Thereafter, without waiving its challenges to the three-judge court's jurisdiction or the order's lawfulness, 09-416-App. 315a, the State timely submitted a plan to the district court. *Id.* at 312a-353a. The State disclosed that even if proposals pending before the legislature were enacted, it could

safely reduce the population to only 151% design capacity within two years. *Id.* at 317a-318a (proposing to meet cap within five years). On October 21, 2009, the court rejected the plan and required the State to submit a plan to timely meet the 137.5% threshold. Slip op. (Oct. 21, 2009) (*Plata* D.E. 2269). Preserving its objections, the State submitted a revised plan. App. 34a (incorporating newly enacted legislation, but stating that the required reduction "can only be accomplished if the State Legislature enacts new laws and/or this Court orders changes to State laws").

On January 12, 2010, the three-judge court issued the "Order to Reduce Prison Population" approving the revised plan. App. 3a-6a. That Order also reaffirmed the August 4, 2009 order. *Id.* at 2a. The court adhered to its conclusions that "crowding is the primary cause" of the constitutional violations and "no relief other than a 'prisoner release order' ... is capable of remedying these constitutional deficiencies," and that the 137.5% cap was "narrowly drawn, would extend no further than necessary to correct the violation of California inmates' federal constitutional rights, and was the least intrusive means necessary." *Id.* The court acknowledged that it had "not evaluated the public safety aspect of the State's proposed plan," but stated that "the evidence presented at trial demonstrated that means exist to reduce the prison population without a significant adverse impact on public safety or the criminal justice system." *Id.* at 3a-4a.

The order requires that within 24 months from its effective date, the State's systemwide prison population be "no more than 137.5% of design capacity," and that the population be "no more than" 167%, 155%, and 147% of design capacity at prior six-month intervals. App. 6a. *Sua sponte*, the court stayed the effective date pending this Court's resolution of any appeal. *Id.* at 8a.

On January 15, 2010, this Court dismissed the State's appeal of the August 4, 2009 order for lack of jurisdiction. *Schwarzenegger* v. *Plata*, 130 S. Ct. 1140, 1140 (2010) (noting "that a further order has been entered in this case, but that order is not the subject of this appeal.... [and] that the district court has stayed its further order pending review by this Court.").

On January 19, 2010, the State timely appealed the "Order to Reduce Prison Population." App. 17a-24a.

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

This case presents questions of substantial importance regarding the prerequisites for issuing a "prisoner release order," in a context that has serious consequences for public safety and our federal system. The substantial, important nature of these issues is clear because Congress vested this Court with exclusive jurisdiction to review any "prisoner release order." Unless this Court notes probable jurisdiction, an unprecedented order requiring the State to reduce its prison population by approximately 46,000 inmates will escape review. Moreover, summary affirmance here would give the three-judge court's decisions unique precedential value in the PLRA's infancy. See *Hicks* v. *Miranda*, 422 U.S. 332, 344-45 (1975).

Even before the PLRA was enacted, courts recognized that population caps represent the highest level of federal court interference with state prison management and a challenge for Our Federalism.

See, *e.g.*, *Taylor* v. *Freeman*, 34 F.3d 266, 268-70 (4th Cir. 1994); *Occoquan*, 844 F.2d at 842-43. Congress sought to further restrain federal court interference with prison conditions through the PLRA. See *Woodford* v. *Ngo*, 548 U.S. 81, 93 (2006); *Taylor* v. *United States*, 181 F.3d 1017, 1027 (9th Cir. 1999) (en banc) (Wardlaw, J., dissenting). The Act takes special aim at prisoner release orders and population caps. See *Castillo* v. *Cameron County, Tex.*, 238 F.3d 339, 348 (5th Cir. 2001); 141 Cong. Rec. S14407, S14414 (daily ed. Sept. 27, 1995) (Sen. Dole) ("Perhaps the most pernicious form of judicial micromanagement is the so-called prison population cap.").

Under the district court's interpretation and application of the PLRA, however, Congress's intent to make a "prisoner release order" the remedy of "last resort" will be subverted. In addition, the "Order to Reduce Prison Population" will interfere with the State's operation of its criminal justice system and severely constrain California's ability to set and fund political priorities during these difficult economic times. The PLRA was enacted to prevent such damage to federalism principles. Probable jurisdiction should be noted.

I. THE THREE-JUDGE COURT LACKED JURISDICTION TO ENTER THE "PRISONER RELEASE ORDER."

The question whether the three-judge court had jurisdiction to consider a prisoner release order in *Plata* and *Coleman* is substantial and worthy of this Court's review. In both cases, the courts wrongly concluded that the State had been allotted "a reasonable amount of time to comply with the previous court orders" before they convened the three-judge court to consider prisoner release. 18 U.S.C. § 3626(a)(3)(A)(ii). Specifically, they failed to give the State a reasonable time period to effectuate the Receiver's and Special Master's recent proposals, despite, for instance, the Receiver's conviction that in time his actions would remedy the alleged constitutional violations.

1. In *Plata*, after the Receiver's appointment become effective in April 2006, the State immediately cooperated with him to address plaintiffs' complaints. On July 5, 2006, he stated that his "mission[] to bring the level of medical care ... up to constitutional requirements will be done." Receiver's First Bi-Monthly Report at 33:1-3, http://www.cprinc.org/docs/court/Receiver1stBiMoR070506.pdf; see Second Bi-Monthly Report at 48:25-27 ("numerous" plans to meet his mission), http://www.cprinc.org/docs/court/Receiver/2ndBiMoR091906.pdf. Just eight months after the appointment became effective, and on the same day that the Receiver requested additional time to submit a "final corrective action plan," *Plata* D.E. 559, at 2:2-4 (Nov. 13, 2006) (capitalization omitted), plaintiffs moved to convene the three-judge court.

On December 19, 2006, the court granted the Receiver's extension request. He filed his Plan of Action on May 10, 2007. It contemplated several years of efforts to remedy the claimed violations. The Receiver attested that the "Plan of Action will work" and that it was "simply wrong" to think that "population controls will solve California's prison health care problems." 09-416-App. 282a.

Nonetheless, in July 2007, the court granted plaintiffs' motion to convene a three-judge court to consider release. 09-416-App. 278a-281a. While admitting that the Receiver "has made much progress," *id.* at 279a-280a, the court held that it was not "require[d] ... to wait more time, potentially years, to see whether the Receiver's plans will succeed or fail," *id.* at 281a (concluding that the Receiver's progress was outweighed by insufficient progress before his appointment).

The court's decision to short-circuit its own remedial process cannot be squared with § 3626(a)(3)(A)(ii), or the PLRA requirement that "prisoner release" be the "'remedy of last resort.'" 09-416-App. 73a. This point is underlined by the record of steady progress in implementing the Receiver's plans *after* the three-judge court was constituted, including the period during and after trial. As the Receiver advised in June 2008, although he and the State were "at the early stages in fully implementing our goals," "[t]here has already been significant progress on some of [his] goals" and "[s]ubstantial work has been completed at several prisons to improve conditions." *Plata* D.E. 1229, at iv. And in January 2010, the Receiver proclaimed "there is much that prison healthcare stakeholders and advocates can showcase as accomplishments." *Plata* D.E. 2289-1, at 5. Indeed, the State has greatly increased funding for and improved access to medical care, dramatically improved staffing, and enhanced its infrastructure and operational capacity. *Id.*

After the Receivership was instituted, the healthcare funding per inmate nearly doubled. *Plata* D.E. 1632 ¶¶ 7-9; Tr. 734:13-736:25. Initiatives to improve access to care at each institution were "ahead of schedule" by September 2008, *Plata* D.E. 1472, at 9, and showed "marked[] improve[ment] throughout 2009, *Plata* D.E. 2289-1, at 5. See *id.* at 9-10 ("[a]ll institutions have reported improvement in patient-inmate access to scheduled healthcare appointments"); *id.* at 15-23 (improvements to medical system).

Moreover, the number of health-care staff increased significantly by the trial date. *Plata* D.E. 1472, at 25 (recruitment efforts "have been very positive" and employment goals had been met at dozens of institutions). When trial began, successful recruiting efforts had brought the State within five and two percent of the Receiver's goals for filling physician and registered nurse positions, respectively. Tr. 445:8-446:14, 447:9-448:5.[5] "Significant gains" continued after trial. *Plata* D.E. 2289-1, at 5, 24-25.

There also have been continuing improvements in operations and infrastructure. For instance, the State has made strides in establishing clinical leadership and management structures. *Id.* at 26; *Plata* D.E. 1472, at 33. It has continued to develop data collection and reporting mechanisms to enhance patient care. *Plata* D.E. 2289-1, at 29. Between the trial and January 2010, the State successfully completed the implementation of peer review programs to ensure better quality of care, and established a medical oversight unit to review potential cases of preventable death and patient harm. *Id.* at 32-35; *Plata* D.E. 1472, at 40, 42-43.

These developments directly improve the healthcare of the *Plata* class. See, *e.g.*, Tr. 445:7-446:14, 447:9-23 (plaintiffs' expert Dr. Shansky testified that increased staffing has improved the quality of care); *id.* at 242:9-243:15, 249:25-250:5 (plaintiffs' expert Dr. Beard acknowledged improvements in care). By the trial date, the number of deaths had been trending downward for 10 quarters, *id.* at 454:21-455:12, and the number of alleged preventable deaths fell from 18 in 2006 to 3 in 2007, *id.* at 450:20-451:2, 486:16-487:5; Shansky Dep. at 74:7-16.

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[5] *See* Defs.' Trial Ex. 1235, at 3 (62 full-time physicians hired between November 2007 and August 2008); *id.* at 2 (number of full-time Chief Physicians and Surgeons almost tripled between October 2005 and August 2008); *id.* at 4 (13-fold increase in Physician Assistants over two years); *id.* at 5 (four-fold increase in Nurse Practitioners in less than three years); *id.* at 7 (licensed vocational nurses climbed from *4* to *937* in 15 months).

2. Similarly, in *Coleman*, plaintiffs moved to convene a three-judge court only eight months after the district court approved new remedial plans. *Coleman* D.E. 1772, 1773 (Mar. 3, 2006). The State was actively implementing those plans at the time. See, *e.g.*, *Coleman* D.E. 1950, 1951, 1990, 2061 (plans re: evaluating psychiatrists, beds, and suicide prevention). In June 2006, the *Coleman* court began ordering the State to coordinate compliance efforts with the newly appointed *Plata* Receiver. *Coleman* D.E. 2063, at 3:10-13.

"In spite of the [State's] commendable progress," 09-416-App. 294a, Judge Karlton convened a three-judge court, *id.* at 295a-296a. Like Judge Henderson, Judge Karlton concluded "[i]t has been almost twelve years since this court found widespread violations of the Eighth Amendment ... [and] Defendants have had more than sufficient time to comply with the mandate required by the court's 1995 order and the numerous orders issued since then." *Id.* at 297a. But like the *Plata* court, the *Coleman* court's focus on previous unsuccessful remedial efforts is inconsistent with § 3626(a)(3)(A)(ii) and with the PLRA requirement that "prisoner release" be the "remedy of last resort." See, *e.g.*, Special Master's May 31, 2007 Response to Request for Information at 6 (*Coleman* D.E. 2253) ("[i]mprovement has occurred over the past dozen years").

For instance, whereas staff vacancies ran high in mid-2007, *id.* at 10-11; Special Master's Nineteenth

Monitoring Report at 114-16 (*Coleman* D.E. 2895) (reporting, *inter alia*, vacancy rates of higher than 40% and functional rates as high as 43% in May 2007), a focused recruiting and hiring program launched in November 2007 led to significant successes in filling positions before and after trial. *Plata* D.E. 1715, ¶¶ 48, 57-60 (discussing, *inter alia*, 18% decrease in vacancy rate for psychologists over a six-month period); Special Master's Twenty-First Monitoring Report at 375 (*Coleman* D.E. 3638) ("As of October 31, 2008, the vacancy rate in mental health staffing at CDCR institutions continued the decline that had been found during the preceding monitoring period.") (footnote omitted); *id.* at 375-78 (noting, *inter alia*, vacancy rates for multiple staff categories had fallen to between 11% and 19%). Indeed, the Special Master recognized that certain facilities were fully staffed. See Tr. 929:2-6, 929:14-22.

Additionally, CDCR hired 600 and 1800 custodial staffers in 2007 and 2008, respectively, and those officers serve in dedicated "access to care" units to escort inmates to medical and mental health appointments. *Id.* at 1894:20-1895:6.[6] The staff recruiting has been so successful that CDCR "literally filled up all of [its] prisons with correctional staffing" and planned to cancel academies for additional staff because "we are actually overfilled." *Id.* at 1895:11-18.

Furthermore, under the Special Master, the State added dedicated mental health beds at various institutions, diminishing mental health bed waiting lists. *Plata* D.E. 1715, ¶ 74; Defs.' Trial Ex. 1186. CDCR institutions implemented functional and effective quality management programs. *Coleman* D.E. 3638, at 379, 381. Numerous institutions satisfied Program Guide requirements for suicide prevention, *id.* at 384; and as in *Plata*, an increased number of institutions improved their provision of medication for class members, see, *e.g.*, *id.* at 390-91 (noting "significant improvement").

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[6] The three-judge court chose not to consider such progress, instead relying on plaintiffs' outdated expert reports to criticize the level of custodial staffing dedicated to provision of medical and mental health care. 09-416-App. 110a.

3. The district courts' decisions to convene a three-judge court despite progress under the interim orders in *Plata* and *Coleman* cannot be reconciled with even pre-PLRA case law. See *Women Prisoners* v. *Dist. of Columbia*, 93 F.3d 910, 929 (D.C. Cir. 1996) (reversing imposition of a population cap and explaining "[t]he court ... should have determined the constitutional propriety of a population cap *at the margin*—that is to say, *after its instructions concerning health and safety measures had been complied with*") (second emphasis added). If the lower courts' approach prevails, a single-judge court may find that insufficient progress at some earlier time vitiates § 3626(a)(3)(A)(ii)'s "reasonable amount of time to comply" requirement, even if current remedial orders show significant progress. Cf. *Casey*, 518 U.S. at 363 & n.8.

Less intrusive measures to address constitutional violations often take substantial time. By enacting the PLRA, Congress made plain its intent that such measures be given a full opportunity to succeed before a three-judge court is convened to consider prisoner release. The improvements detailed above individually and cumulatively demonstrate that the single-judge courts prematurely convened the three-judge court. Accordingly, that court lacked jurisdiction to issue the "Order to Reduce Prison Population."

II. THE COURT'S INTERPRETATION OF § 3626(a)(3)(E) IS CONTRARY TO THE PLRA AND WOULD GREATLY EXPAND THE AVAILABILITY OF "PRISONER RELEASE ORDERS."

Section 3626(a)(3)(E) requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right; and ... no other relief will remedy the violation" before issuing a "prisoner release order." The court's interpretation of § 3626(a)(3)(E) presents substantial questions for review.

In finding that overcrowding is the primary cause of constitutional violations, the court did not give the word "primary" its natural meaning. It found overcrowding a primary cause of the medical and mental healthcare inadequacies simply because crowding contributed to those problems and impeded their solution. That interpretation contravenes the statute's plain meaning and Congress's purposes. See 09-416-App. 126a n.55 (the primary cause determination is "'a question of law'"). It allowed the court to order prisoner release despite its simultaneous finding that the 137.5% cap would not remedy the alleged Eighth Amendment violations. At a minimum, the elimination of the "primary cause" of a constitutional violation should "remedy the violation of the Federal right."

Moreover, the court's finding that plaintiffs presented "clear and convincing" evidence that less intrusive measures could not remedy the alleged constitutional violations is unsustainable. All of the court's findings with respect to § 3626(a)(3)(E) were artificial because it did not analyze—and appellants were prohibited from taking discovery from the Receiver or the Special Master, and introducing evidence about—the "current and ongoing" nature of alleged federal violations.

1. Congress did not define the statutory phrase "primary cause," nor does the legislative history address it. See 09-416-App. 79a & n.43. Although the three-judge court purported to accept the State's interpretation of the requirement, *id.* 78a ("the cause that is 'first or highest in rank or importance; chief; principal'"), it did not apply that interpretation. Instead, in finding that overcrowding was the "primary cause" of the alleged constitutional violations, the court used a standard that made crowding a *contributing cause* of the violations. See *Black's Law Dictionary* 250 (9th ed. 2009) ("contributing cause" is "[a] factor that—though not the primary cause—plays a part in producing a result").

The court recognized that myriad causes for the alleged violations exist, many of which pre-date the crowding at issue. See 09-416-App. 16a-17a, 31a-52a, 104a-126a. And, the court acknowledged that curing the crowding would not remedy the alleged violations because independent (primary) causes would continue to produce constitutional injury. *Id.* at 134a, 143a.

In these circumstances, crowding cannot be the primary cause of the alleged constitutional violations because it is not their proximate and "but for" cause. See *Rocco* v. *Lehigh Valley R.R.*, 288 U.S. 275, 278-80 (1933) (discussing "primary" and "proximate" causation under the Federal Employers' Liability Act); *The G.R. Booth*, 171 U.S. 450, 460-61 (1898) (discussing "proximate" and "primary causation"); *Metro. Pittsburgh Crusade for Voters* v. *City of*

Pittsburgh, 964 F.2d 244, 251 (3d Cir. 1992) (a "primary cause" encompasses "but for" and "proximate" causation; such standards are "significantly more stringent than [a] 'material contributing factor' test") (citations omitted). In other contexts, courts recognize that it is much easier for a litigant to satisfy a "contributing factor" test than to demonstrate that a particular circumstance is the "primary cause" of a statutory violation. *Hawkins* v. *Dir., Office of Workers Compensation Programs*, 907 F.2d 697, 705 n.12 (7th Cir. 1990) (Black Lung Benefits Act); *Borras* v. *Sea-Land Serv., Inc.*, 586 F.2d 881, 885-86 (1st Cir. 1978) (Jones Act).

By finding that crowding is the primary cause here, the district court effectively nullified § 3626(a)(3)(E)(ii). That provision assumes that by addressing "crowding," the prisoner release order will do what lesser relief could not: "remedy the violation of the Federal right." If overcrowding is the primary cause of any violation, then eliminating overcrowding should undo all or virtually all constitutional harm. The record makes clear that this would not be true here.

Before the three-judge court was convened, *Coleman* and *Plata* were not litigated as cases about crowding. The underlying alleged violations involved the delivery of medical and mental health care. Accordingly, the thrust of orders entered by the single-judge courts was directed, not at crowding, but at problems such as recruitment and retention of qualified personnel, medical leadership, medical equipment, screening systems, systems to track patients with needs, record keeping, and institutional culture. See 09-416-App. 16a-17a, 22a-23a, 33a-36a. The *Coleman* Special Master, the *Plata* Receiver, and plaintiffs' expert agreed that even if the crowding is remedied, these pre-existing problems will continue to cause the alleged constitutional violations.[7]

The lower court's interpretation of § 3626(a)(3)(E) therefore allows a three-judge court to order prisoner release whenever it is frustrated with the speed or ability of less intrusive relief to remedy the violations of federal rights—even though the federal violations will continue after the release occurs. See 09-416-App. at 134a, 143a. This fails to give meaning to Congress's intent to make prisoner release the PLRA's "'the remedy of last resort.'" *Id.* at 73a.

2. The three-judge court concluded that overcrowding was the primary cause of the constitutional violations because it believed that "all other potential remedies will be futile in the absence of a prisoner release order." 09-416-App. 144a-145a. The court's view is not supported by the record, let alone clear and convincing evidence.

Initially, the three-judge court's analysis is inconsistent with the testimony of plaintiffs' experts. They repeatedly opined that constitutionally adequate medical and mental health care can be provided in severely overcrowded prisons, claiming that they had done so in the state prison systems they administered. See Tr. 241:2-6, 252:7-253:25 (Dr. Beard); *id.* at 212:5-214:10 (testifying that although it "is impossible to really do a good job" when prison population is at 150-60% of design capacity, he ran a prison at over 200% design capacity); *id.* at 285:21-286:14 (Dr. Lehman); *id.* at 457:1-13, 478:7-479:16 (Dr. Shansky).

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[7] *See, e.g.*, Deposition of Dr. Shansky at 61:14-24 (Dec. 10, 2007) (*Plata* D.E. 1481, Ex. A) (testifying the CDCR will not have constitutionally adequate medical care delivery "[i]f the only improvement that was made in the next two years is ... there are 40,000 less inmates"); *Plata* D.E. 673, at 42:24-43:1 (Receiver: it is "simply wrong" to believe "that population controls will solve California's prison health care problems"); Receiver's Turnaround Plan of Action at ii-iv, 1-20 (*Plata* D.E. 1229); 09-416-App. 157a-158a (Special Master: "'even the release of 100,000 inmates would likely leave the defendants with a largely unmitigated need to provide intensive mental health services to program populations'") (alteration omitted).

The court's conclusion is further undermined by its failure to consider the ongoing improvements in *Plata* and *Coleman* described *supra* § I (failure to consider progress infects analysis of jurisdiction to convene a three-judge court). This evidence was plainly relevant to a determination whether plaintiffs had established, by clear and convincing evidence, that a prisoner release order was required because "no other relief" would suffice. See 09-416-App. 145a-162a (discussing purported inadequacy of less intrusive remedies). The three-judge court erred by considering each of the potential remedial measures in isolation rather than examining their cumulative effect, by unreasonably dismissing the individual effectiveness of those potential remedies, and by failing to consider the most current evidence of progress.

Additional Hiring. The court rejected additional hiring as a less intrusive form of relief. See 09-416-App. 154a-155a. As shown *supra* § I, the hiring trends affecting the *Plata* and *Coleman* class members were extremely positive between 2007 and 2008. The court declined to recognize these improvements although the State introduced evidence of such progress at trial. See, *e.g.*, *supra* 14-15 & n.5. Instead, the three-judge court relied on the state of staffing in 2007 and before, to dismiss additional hiring as a potential remedy. 09-416-App. 154a; see *id.* 47a-48a & nn.31-34 (staffing between

1998 and 2007); *id.* at 28a (staffing in 2005). But, had the court considered the actual state of hiring, it would have concluded that plaintiffs failed to establish, by clear and convincing evidence, that continued staffing increases—whether alone or in concert with other measures—would not have remedied the alleged violations of the class members' rights.

The Receiver and the Special Master's Ability to Remedy Alleged Violations Absent Release. The court's claim that the tools available to the *Plata* Receiver and the *Coleman* Special Master were insufficient to remedy the alleged violations of plaintiffs' rights absent a prisoner release order is not supported by clear and convincing evidence. See 09-416-App. 155a-159a. For instance, as plaintiffs' expert testified: "'[Q.] Is it your opinion that no matter what resources he has or what actions he takes, the Receiver cannot provide for constitutional levels of medical care at current population levels? [A.] No.'" Tr. 1430:2-6.

Most notably, the court apparently declined to credit Dr. Shansky, *plaintiffs' expert*, when he testified that that some prisons already may be providing constitutional levels of care, notwithstanding their overcrowding. Tr. 456:11-15. He also testified that if the Receiver's Turnaround Plan were fully implemented, it would "ensure a constitutional level of healthcare and mental healthcare" even without prisoner release. *Id.* at 491:1-492:8.

By plaintiffs' counsel's estimation, certain facilities that previously had provided constitutionally inadequate care showed marked improvements despite very large populations. For instance, plaintiffs' report following their February 2007 visit to the Central California Women's Facility, whose population was 195.2% of design capacity, stated that "[b]ecause of the overall progress implementing the *Plata* policies and procedures," in-person monitoring visits to the facility would no longer be necessary. Defs.' Trial Ex. 1074, at 1. They noted that the facility was "fully staffed" and the prison had "eliminated" a previous backlog. *Id.* at 4-10; see also Office of the Inspector Gen., *Central California Women's Facility: Medical Inspection* Results 1-2, 7-28 (2009), *at* http://www.cprinc.org/docs/resources/OIG_CCWF_MedInspectionResults_200904.pdf (reporting multiple 100% scores for compliance with Receiver's policies and procedures as well as many other scores above 80% compliance). Similarly, plaintiffs' report of their March 2008 visit to Mule Creek State Prison, whose population exceeded 215% of design capacity, stated that its "'compliance with key access to care time frame requirements ... is generally very good at present time.'" Tr. 441:18-442:12; *id.* at 440:24-25. And, following a July 2007 visit to CSP-Solano, whose population was 230.8% of design capacity, plaintiffs reported that they found just "a few areas" in which the facility was "out of compliance with the *Plata* Policies and Procedures." Letter from Zoe Schonfeld, Prison Law Office 2 (July 10, 2007).

In all events, any conclusion that the Receivership and Special Mastership would have been unable to remedy the alleged violations of the *Plata* and/or *Coleman* class members' constitutional rights must be rejected because of the evidentiary limitations imposed before and during trial. The State was unable to gather and introduce the most relevant evidence on this point, namely the Receiver's and the Special Master's views on whether a prisoner release order was necessary. *Supra* 7.

Moreover, the three-judge court gave no weight to the positive developments under the Receivership and Special Mastership that occurred between the August 30, 2008 close of evidence and the close of trial. See *supra* § I (discussing progress after that date).[8] The court precluded the State from "introduc[ing] ... evidence relevant only to determining whether the constitutional violations found by the *Plata* and *Coleman* courts were 'current and ongoing.'" 09-416-App. 78a n.42.[9] The court stated that it had no need to consider these issues because the single-judge district courts had "both found, without objection from defendants, that constitutional violations were ongoing" in July 2007, and "defendants ha[d] never filed a motion to terminate under § 3626(b), the proper means for any challenge to the existence of 'current and ongoing' constitutional violations." *Id.* at 77a.

The three-judge court's reasoning is unsound. Particularly in light of the successes discussed above, *supra* § I, the State's failure to dispute whether violations were ongoing *16 months before trial* says little about the status of the alleged constitutional violations during trial—let alone on August 4, 2009 or at issuance of the "Order to Reduce Prison Population" now on appeal. The State's decision not to move to terminate proceedings (requiring a showing that *all* constitutional violations had been remedied) does not indicate either which violations had been cured or what measures are necessary to address remaining violations, if any.

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[8] Furthermore, the court did not consider evidence of the improvements between the trial and its January 12, 2010 order. *Compare supra* § I.

[9] The court repeatedly ruled that evidence would not be allowed to prove current constitutional conditions. *See, e.g.*, *Plata* D.E. 1786, at 28:16-29:2; Tr. at 6:24-7:9.

The record lacks the "clear and convincing" evidence required to support prisoner release.

Out-of-State Transfers. The three-judge court reasoned that the number of transfers to date and proposed in the future were "too small to significantly affect the provision of medical and mental health care to California's inmates." 09-416-App. 160a. The court erred in rejecting the possibility of transferring California inmates to out-of-state facilities as a less intrusive remedy. *Id.* at 159a-162a.

The State sought to transfer greater numbers of prisoners housed in CDCR institutions to out-of-state facilities, but Judge Karlton prohibited it from doing so. See slip op. at 2 (Nov. 6, 2006) (*Coleman* D.E. 2025) (allowing 80 inmates' transfer, but ordering that "[n]o other CDCR inmates are to be transferred"); cf. Cal. Code Regs. tit. 15, § 3379(a)(9)(F)(2), (G)(1)-(2) (regulations promulgated as a result of Judge Karlton's order, prohibiting transfer of class members absent a court order). Thus, despite the findings that CDCR facilities were providing unconstitutional care, Judge Karlton refused to transfer inmates to facilities outside California—where they would have received care that satisfied the Eighth Amendment.[10] In these circumstances, the three-judge court should have refused to order prisoner release unless the district courts allowed the

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[10] Ironically—given the State's alleged "deplorable" care, 09-416-App. 20a, 280a—the court prohibited additional transfers because of the Special Master's concern, *Coleman* D.E. 2025, at 2 ¶ 3, that "the actual state of mental health services" at the *out-of-state transferee institutions* would not provide sufficiently high quality care. *See id.*, Ex. 1, at 3.

State to exhaust its avenues for prisoner transfer. Absent such an effort, plaintiffs could not have proven by clear and convincing evidence that transfers of CDCR inmates would not remedy any constitutional violations.

Construction. The court also rejected the State's argument that its desire to implement AB 900 and its willingness to construct facilities would constitute less intrusive remedies than prisoner release. See 09-416-App. 145a-154a. The court declined to credit plaintiffs' experts' testimony that prison construction helped remedy federal law violations in systems they administered, Tr. 287:10-20, 289:18-20, and that the construction of additional treatment facilities in California could remedy the alleged violations, *id.* at 254:25-256:8, 457:1-458:6.

The court dismissed the State's construction proposals as infeasible because "it will be years before any re-entry facility construction ... will be completed." 09-416-App. 147a-148a; *id.* at 149-150a. The court's reasoning is internally inconsistent. The court *sua sponte* stayed its prisoner release order pending appeal; once effective, that order will take *two years* to implement. In this time, construction that could be a partial remedy will occur. The prisoner release order was not the "'the remedy of last resort.'" *Id.* at 144a.

The court failed properly to account for these intrusive measures individually and cumulatively, which could remedy the alleged constitutional violations. The decision below thus presents substantial questions warranting plenary review.

III. THE COURT'S INTERPRETATION OF THE PLRA'S NEXUS AND NARROW TAILORING REQUIREMENTS IS DEEPLY FLAWED.

Even if § 3626(a)(3)(E) were satisfied, the scope of the prisoner release order raises substantial questions worthy of review.

The district court has imposed an inflexible population cap, 137.5% of the prisons' combined design capacity, that must be met within two years. App. 5a-6a; see *id.* at 13a (*Coleman* order incorrectly requiring that a particular institution's population immediately satisfy the 137.5% cap). The "Order to Reduce Prison Population" is not "narrowly drawn," it extends "further than necessary to correct the [alleged] violation" of the *class members*' rights, and does not give sufficient weight to adverse impacts on public safety and the operation of the State's criminal justice system. 18 U.S.C. § 3626(a)(1)(A).

1. The three-judge court expressly stated that "the relief sought by plaintiffs extends further than the identified constitutional violations" insofar as it "is likely to affect inmates without medical conditions or serious mental illnesses." 09-416-App. 172a. The population cap addresses the prison population as a whole, not only members of the plaintiff-classes. On its face, the relief violates the PLRA because it is not "narrowly drawn" and is broader than necessary to "correct the violation of the Federal right of ... particular ... plaintiffs," *i.e.*, the class members. 18 U.S.C. § 3626(a)(1)(A); see H.R. Rep. No. 104-21, at 24 n.2 (1995) ("[T]he provision stops judges from imposing remedies intended to ... provide an overall improvement in prison conditions.").

The court's holding also conflicts with the Eighth Circuit's interpretation of the statute's narrow-tailoring requirement. See *Hines* v. *Anderson*, 547 F.3d 915, 922 (8th Cir. 2008) (decree is "not narrowly drawn" because it addressed medical care generally, not "a particular medical problem that existed at the time"). Moreover, it violates this Court's holdings that "'federal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate the Constitution or does not flow from such a violation.'" *Missouri* v. *Jenkins*, 515 U.S. 70, 98 (1995) ("*Jenkins II*"); *id.* at 90-92.

Additionally, by directing the prisoner release order at *all* California prisoners, the relief intrudes on the State's management of its criminal justice system. This contravenes § 3626(a)(1)(A)'s requirement that the court "give substantial weight to any adverse impact on ... the operation of the criminal justice system." See also 141 Cong. Rec. S2647, S2649 (daily ed. Feb. 14, 1995) (Sen. Hutchison). And this significant invasion of the State's managerial prerogatives vis-à-vis the general prison population violates this Court's limits on the scope of equitable relief generally and in prison-conditions litigation specifically. See, *e.g.*, *Turner* v. *Safley*, 482 U.S. 78, 84 (1987); *Bell* v. *Wolfish*, 441 U.S. 520, 548 (1979).

This Court should review this case to ensure that the PLRA's requirements are given the meaning Congress intended and that courts do not impose prison population caps other than as a last resort.

2. Additionally, plaintiffs failed to establish that the 137.5% of design capacity cap is "narrowly drawn, extends no further than necessary ... , and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). The court treated design capacity as a synonym for the appropriate prison population and overcrowding as a constitutional violation; it erred in both respects.

To understand plaintiffs' failings, it is critical to understand what "design capacity" means in California's prisons. It refers to the number of inmates a prison may house based on one inmate per cell, single bunks in dormitories, and no beds in space not designed for housing. 09-416-App. 57a. California, however, "has never limited its prison population to 100% design capacity," because, *inter alia*, its prisons frequently were planned and built to double-cell inmates. *Id.* A facility intended to house two inmates per cell that houses two inmates in each cell (and thus is not overcrowded) is nonetheless at 200% of "design capacity."

Equally important, housing two inmates in a cell designed for one does not violate the Eighth Amendment. ***Rhodes v. Chapman***, 452 U.S. 337, 348 (1981). Overcrowding alone does not violate the Eighth Amendment. See *Hoptowit* v. *Ray*, 682 F.2d 1237, 1249 (9th Cir. 1982). Instead, plaintiffs must show that the State is failing to provide medical and mental health care consistent with "the minimal civilized measure of life's necessities," ***Rhodes***, 452 U.S. at 347, and is acting with "deliberate indifference to serious medical needs of prisoners" resulting in "'unnecessary and wanton infliction of pain.'" ***Estelle*** v. ***Gamble***, 429 U.S. 97, 104-05 (1976); see ***Wilson*** v. ***Seiter***, 501 U.S. 294, 298-302 (1991).

Plaintiffs' experts repeatedly recognized that constitutionally adequate medical and mental health care can be provided in prisons where the population far exceeds design capacity. ***Supra*** 21-22. Plaintiffs nonetheless sought a cap at 130% of design capacity—"the federal standard for prison overcrowding," 09-416-App. 180a—without linking that population level to the State's ability to satisfy its constitutional obligations. *Id.* at 183a. Put differently, they failed to show that California's prisons must meet the federal standard for prison overcrowding to provide constitutionally adequate medical and mental health care.

Plaintiffs sought a population cap based on expert opinions concerning the level required for a "prison system ... to function *properly*" or "'*appropriately*.'" 09-416-App. 177a-178a (emphases added). Plaintiffs' experts denied that they could assess the population reduction required to provide inmates with care that satisfied the Eighth Amendment:

> [Q.] Isn't it true ... that you hesitate today to come up with a figure to which the prison population needs to be reduced to achieve constitutional levels of care, because ... that would require doing a study that requires data from the Plata Receiver?
>
> A. Yes, that's correct.

Tr. 483:7-12 (Dr. Shansky); *id.* at 490:4-14 (he had "'no clue'" what the number would be); *id.* at 342:15-23 (Dr. Haney: "[Q.] 'Are you aware of what objective standard must be met by [CDCR] in order to show compliance with the elements of providing sufficient mental health beds for the mental healthcare population to show a constitutional compliance? ... [A.] No, ... I don't know how to calculate that.'").

Instead of linking a particular population level to the abridgement of Eighth Amendment rights, Dr. Beard, like many of plaintiffs' experts, testified about the difficulties that crowding creates for a warden. See Tr. 205:12-14 ("any time that you're running over capacity ... you have more possibilities of having problems"). Critically, he also testified that he had operated prisons whose populations were 150-160% and over 200% of design capacity, opining that doing so was "difficult"—not that the care provided was in violation of the Eighth Amendment—and that "it is impossible to really do a *good job* with prisons that large." *Id.* at 213:1-214:10 (emphasis added).[11]

On this record, the three-judge court lacked a sufficient basis to conclude that "California's prisoner population *must* be reduced to some level between 130% and 145% design capacity if the CDCR's medical and mental health services are ever to attain constitutional compliance." 09-416-App. 143a (emphasis in original). It selected a system-wide cap of 137.5% design capacity solely because it was "halfway between the cap requested by plaintiffs [*i.e.*, the federal standard for overcrowding] and the wardens' estimate of the California prison system's maximum operable capacity absent consideration of the need for medical and mental health care." *Id.* at 184a. This is the antithesis of narrow tailoring.

Without evidence of the population level at which the State could not provide "the minimal civilized measure of life's necessities," ***Rhodes***, 452 U.S. at 347, the court substituted professional standards and desirable benchmarks for constitutional requirements. This conflicts with well-established requirements for assessing and remedying alleged constitutional violations. As recognized in ***Rhodes***, a lower court "err[s] in assuming that opinions of experts as to desirable prison conditions suffice to establish contemporary standards of decency.... '[T]hey simply do not establish the constitutional minima; rather, they establish goals recommended by the organization in question.'" *Id.* at 348 n.14 (quoting *Wolfish*, 441 U.S. at 544 n.27); *accord Occoquan*, 844 F.2d at 837; *Hoptowit*, 682 F.2d at 1249.

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[11] Plaintiffs' experts were unaware of the level of care provided to the class members and had not evaluated CDCR's delivery of care. *See, e.g.*, Tr. 278:4-7 (Lehman: "Q. In preparing your report, you did not know what the space needs were for medical or mental healthcare in California's prisons, did you? A. Specifically, no."); *id.* at 279:4-6 ("Q. ... You did not have knowledge of the status of medical health care delivery in California's prisons as of August 2008, did you? A. No ....").

3. As shown *supra* § II, the order does not satisfy the PLRA's nexus and narrow tailoring requirements because it lacks any connection to the Eighth Amendment violations alleged to persist at the trial. See *Jenkins II*, 515 U.S. at 88. The mandatory starting point for analyzing the nexus between the alleged violations and their remedy was an inquiry into the nature of the current federal violations. The court failed to conduct that inquiry. As a result, the court's conclusions about the required scope of the remedy lacked sufficient basis in the record and cannot stand. See *id.* ("'federal-court decrees must directly address and relate to the constitutional violation itself'").

4. Finally, the court failed to meaningfully account for the order's adverse impacts on public safety. 18 U.S.C. § 3626(a)(1)(A). The PLRA's core purpose was to ensure that any prisoner release order provided substantial protection to the public. See *id.*; see also H.R. Rep. No. 104-21, at 9 (1995); 141 Cong. Rec. at S14418 (Sen. Hatch). The court's order fails this test.

The three-judge court candidly acknowledged that the order was likely to increase crime without substantial investment in "evidence-based rehabilitation programming," 09-416-App. 241a-248a—"*i.e.*, programs that research has proven to be effective in reducing recidivism," *id.* at 214a; see *id.* at 200a. However, the court neither found that such programming could be expanded nor calculated the costs of an expansion. Plaintiffs failed to introduce evidence on these points, and did not carry their burden. See *Mazurek* v. *Armstrong,* 520 U.S. 968, 972 (1997) (per curiam) (to obtain injunctive relief, the movant, "'by a clear showing, carries the burden of persuasion'") (emphasis omitted); *Gomez* v. *Vernon,* 255 F.3d 1118, 1129 (9th Cir. 2001) (discussing the "public safety" consideration codified in the PLRA, and explaining that plaintiffs still bear the burden of showing an entitlement to relief) (alteration omitted). Further, in light of the State's financial condition, it is more unlikely that such programming could be made available. See 09-416-App. 11a n.4, 187a.

Moreover, in the "Order to Reduce Prison Population," the court acknowledged that it "ha[d] not evaluated the public safety aspect of the State's proposed plan," but assumed that public safety could be assured because the State's experts had previously recommended measures for safely reducing the population. App. 3a-4a. Given the State's financial condition, reliance on such previous recommenddations—which presumed cooperation of the legislature and an ability to organize its budgetary priorities without federal court assistance—is unreasonable. The court's order raises substantial questions whether § 3626(a)(1)(A) has been satisfied.

* * *

The court below entered an unprecedented order that intrudes on the State's authority over its prison system and constrains the State's ability to respond to problems within its prison system and more broadly throughout California. The three-judge court has dictated to the State the single method it must use (prisoner release) to address alleged constitutional violations involving healthcare without fulfilling the PLRA's requirements–a statute Congress enacted to protect the State's prerogatives with respect to prisoner release so that the State can protect its citizens.

Because Congress recognized the federalism concerns inherent in such an order, it mandated appellate review by this Court. Every issue decided by the court below is one of first impression. This alone provides a sufficient basis for this Court to note probable jurisdiction. But what makes the need for review particularly acute is that the court below has provided any court frustrated by the pace of judicial remedies in prison litigation with a roadmap to use to order prisoner release, instead of remedies trained on the constitutional violation at issue. This Court's plenary review is necessary to forestall that result.

CONCLUSION

The Court should note probable jurisdiction.

Respectfully submitted,

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APPENDIX

APPENDIX A

IN THE UNITED STATES DISTRICT COURTS FOR
THE EASTERN DISTRICT OF CALIFORNIA AND
THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

[Filed 1/12/10]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,

Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants.

ORDER TO REDUCE PRISON POPULATION

On August 4, 2009, this three-judge court issued an Opinion and Order finding, by clear and convincing evidence, that crowding is the primary cause of the constitutional inadequacies in the delivery of medical and mental health care to California inmates and that no relief other than a "prison release order," as that term is broadly defined by the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626(g)(4), is capable of remedying these constitutional deficiencies. We further concluded that relief requiring the State to reduce the population of its thirty-three adult prisons to 137.5% of their total design capacity was narrowly drawn, would extend no further than necessary to correct the violation of California inmates' federal constitutional rights, and was the least intrusive means necessary to correct that violation. Accordingly, in consideration of this court's limited role and the State's "wide discretion within the bounds of constitutional requirements," *Bounds v. Smith*, 430 U.S. 817, 832-33 (1977), we ordered the State to provide "a population reduction plan that will in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity." Aug. 4, 2009 Opinion and Order at 183. As required by the PLRA, we also gave "substantial weight to any adverse impact on public safety or the operation of a criminal justice system," 18 U.S.C. § 3626(a)(1)(A), and determined, based on the evidence presented at trial, that means exist by which the defendants can accomplish the necessary population reduction without creating an adverse impact on public safety or the operation of the criminal justice system.

The State submitted a proposed prison population reduction plan on September 18, 2009, but that proposed plan would have reduced the prison population to only 166% of design capacity in two years absent further legislation, and 151% of design capacity in two years if all of the proposals were granted legislative approval. Defs.' Sept. 18, 2009 Plan at 15, 19 (tables showing projected prison populations and crowding rates based on defendants' proposed population reduction mechanisms). Because the plan that the State provided did not comply with our August 4, 2009 Order, we rejected the plan and ordered the State to submit a revised population reduction plan that complied with our August 4 Order. On November 12, 2009, the State timely submitted a revised plan. In accordance with our Orders, this revised plan proposed measures estimated to reduce the prison population to the required 137.5% of design capacity by December 2011.

On December 7, 2009, plaintiffs agreed that the State's revised plan satisfied the requirements of our August 4, 2009 Order and proposed that we enter an order requiring the defendants to achieve the six-month population reduction benchmarks set forth in the revised plan without ordering implementation of any specific population reduction measures. We agree that such an order is appropriate because it would afford the State maximum flexibility in its efforts to achieve the constitutionally required population reduction.

As defendants and county intervenors observe in their December 18, 2009 replies to plaintiffs' response, we have not evaluated the public safety impact of each individual element of the State's proposed plan. However, the evidence presented at trial demonstrated that means exist to reduce the prison population without a significant adverse impact on public safety or the criminal justice system. Certain of the measures suggested by the State, such as raising the threshold for grand theft and limiting the maximum sentence for certain enumerated felonies to 366 days to be served in county jail, were not included within the means we considered in our August 4 Opinion and Order, and were thus not evaluated from the standpoint of public safety. We noted, however, that they had previously been endorsed by state officials, and thus, presumably, "would not have an adverse effect on public safety." Aug. 4, 2009 Opinion and Order at 156. Certain measures that we concluded would substantially reduce the prison population that we did evaluate positively from a public safety standpoint, such as changes with respect to the churning of technical parole violators, appear to be included only in part in the State's plan. We believe, as we did when we issued our prior Order, that it is appropriate for the State to exercise its discretion in choosing which specific population reduction measures to implement, and, in doing so, to bear in mind the necessity for ensuring the public safety. We are satisfied that, as we previously held, the reduction in prison population that we have ordered can be implemented safely and trust that the State will comply with its duty to ensure public safety as it implements the constitutionally required reduction. Should the State determine that any of the specific measures that it has included in its plan cannot be implemented without significantly affecting the public safety or the criminal justice system, we trust that it will substitute a different means of accomplishing the constitutionally required population reductions.

We emphasize here that we are not endorsing or ordering the implementation of any of the specific measures contained in the State's plan, only that the State reduce the prison population to the extent and at the times designated in this Order. We also emphasize that we do not intend by this Order to prohibit the State from taking actions that may have the effect of reducing the prison population, whatever their impact on public safety, should those actions be taken for reasons other than compliance with our Order.

The concerns that county intervenors express regarding funding may have merit. Counties may well require additional financial resources from the State in order to ensure that no significant adverse public safety impact results from the State's population reduction measures. Counties may, for example, need additional financial resources in order to fund the additional costs of ongoing rehabilitation, re-entry, drug or alcohol, educational, and job training programs. Reducing the number of persons it imprisons should result in significant savings to the State. We do not now decide whether and to what extent the State should allocate part of its savings from such reductions to the counties; instead, we note that whether public safety requires such a reallocation demands serious consideration by the State, both under its general responsibilities to the public and in accord with the PLRA.

In light of all of the above, as well as our August 4, 2009 Opinion and Order, IT IS HEREBY ORDERED that:

1. In accordance with the figures in defendants' November 12, 2009 revised population reduction plan,

defendants shall reduce the population of California's thirty-three adult prisons as follows:

a. To no more than 167% of design capacity by six months from the effective date of this Order.

b. To no more than 155% of design capacity by twelve months from the effective date of this Order.

c. To no more than 147% of design capacity by eighteen months from the effective date of this Order.

d. To no more than 137.5% of design capacity by twenty-four months from the effective date of this Order.

"Design capacity" for purposes of these benchmarks may not remain static. For example, an increase in design capacity through construction would decrease the number of inmates by which the prison population must be reduced. Conversely, a decrease in design capacity, such as would result from the closing of a prison, would increase the numeric reduction required.

2. All population reduction measures undertaken by defendants must comply not only with our Orders and the PLRA, but also with any relevant orders entered by other courts, including the individual *Plata* and *Coleman* courts.

3. Within fourteen days following each of the deadlines described above, defendants shall file a report advising the court whether the estimated population reduction has been achieved. This report shall include the total reduction in the population of California's adult prisons that has been achieved; the current population of those institutions, both in absolute terms and as a percentage of design capacity; and the reductions associated with each of the in-

dividual measures that defendants described in their November 12, 2009 plan as well as any additional or alternative population reduction measures that it may have subsequently adopted. If the State has failed to achieve the required population reduction, defendants shall advise the court as to the reasons for such deficiency and what measures they have taken or propose to take to remedy it. They also shall advise the court as to whether such deficiency could have been avoided by the exercise of executive authority, such as that invested in the Governor and other officials by the California Emergency Services Act. Finally, defendants shall advise the court whether legislative changes are required to remedy any deficiency and, if so, what efforts defendants have made to obtain such changes, including specific proposals made to the legislature and the legislative responses to such proposals. Defendants are advised that we may also order the submission of interim reports informing the court of what specific tasks defendants intend to undertake during each six-month period and the specific persons responsible for executing those tasks.

4. If, at any time, the State believes that the waiver of state law by this court is necessary to permit it to meet any of the above population reduction deadlines, defendants shall promptly file a statement with this court, explaining the reasons that they believe such waiver to be necessary; whether they have considered and rejected all other available remedies; if they have rejected such remedies, the reasons therefor; and why the proposed waiver is permissible under the PLRA and the Constitution of the United States.

5. To the extent that population reduction measures implemented by the State increase the need for re-entry, rehabilitation, education, job training or other community services provided by the counties, or necessitate other measures be under-taken by such counties, defendants shall, in cooperation with the counties, calculate the amount of additional funds that the counties may require from the State in order to maintain the level of public safety at or about the existing level. Within thirty days of the effective date of this Order, defendants shall file with this court a statement setting forth (1) the amounts agreed upon or, should there be no agreement, the parties' respective positions as to such amounts, and (2) what steps defendants have taken or plan to take to fulfill their obligations to the counties in connection with the implementation of the prison population reduction measures, including the allocation to the counties of a portion of any budgetary savings resulting from such implementation. It would be in the interest of both the State and the counties to commence such discussions prior to the effective date of this Order.

6. The effective date of this Order is STAYED pending the United States Supreme Court's consideration of the appeal of our August 4, 2009 Opinion and Order and any appeal of this Order. Unless this Order is rendered moot by the Court's disposition of any such appeal, the effective date of this Order shall be the day following the final resolution by the Court of a timely-filed appeal of this Order or, if no such appeal is filed, the later of the day following the expiration of defendant's time for filing an appeal and the day following the Court's final resolution of the appeal of our August 4 Opinion and Order.

7. We note that this stay grants the State additional time in which to reduce the population of its adult prisons, which Defendant Governor Arnold Schwarzenegger has proclaimed are in a state of emergency due to overcrowding. *See* Ex. P1 (Oct. 4, 2006 Prison Overcrowding State of Emergency Proclamation). In addition, the stay affords defendants the time and opportunity to seek legislation enacting those prisoner population reduction measures that they proposed in their November 12, 2009 revised plan, but asserted that they lacked the authority to implement. We also note that defendants represented in their November 12, 2009 plan that they would seek legislation affording them such authority. Accordingly, within fourteen days of the effective date of this Order, defendants shall file a report advising this court whether they have obtained the requisite authority for such measures or for other alternative measures that would achieve equal or greater reductions in the prison population, and, if not, what efforts they have made towards obtaining such authority, including what specific proposals they have made and what specific responses have been received from the legislature, if any.

As we have repeatedly stated, we do not intervene lightly in the State's management of its prisons. However, the State's long-standing failure to provide constitutionally adequate medical and mental health care to its prison inmates has necessitated our actions, and our prison population reduction Order is the least intrusive remedy for the constitutional violations at issue. We reiterate our "hope that California's leadership will act constructively and cooperatively . . . so as to ultimately eliminate the need for further federal intervention." Aug. 4, 2009 Opinion and Order at 182. We do, however, necessarily reserve the right, and indeed we have the obligation, to order additional steps to implement our August 4 Order should the actions taken by the State fail to meet any six-month reduction goal set forth in this Order.

IT IS SO ORDERED.

DATED: 01/12/10

/s/ STEPHEN REINHARDT
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

DATED: 01/12/10

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

DATED: 01/12/10

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

Following a hearing on September 22, 2009, defendants were directed to file within forty-five days a detailed long-range bed plan, including activation schedules. *See* Sept. 24, 2009 Order, at 3. On November 6, 2009, defendants filed a long-range bed plan. On November 30, 2009, plaintiffs filed a response to defendants' plan and a request for evidentiary hearing on certain aspects of the plan. On December 11, 2009, defendants filed a response to plaintiffs' response, and on December 18, 2009, plaintiffs filed a reply and a renewed request for evidentiary hearing. The court has reviewed all of the papers filed by the parties, and has consulted with the special master.

Several areas of defendants' plan are not in dispute and will be approved by the court. Three areas of dispute require resolution. First, pursuant to the court's September 24, 2009 order, all projects in the long-range plan are to be "fully staffed and activated by the 2013 target date" previously established by defendants. Sept. 24, 2009 Order, at 3. The activation schedules for three of the projects in the long-range plan, the Consolidated Care Center (CCC)[1], that part of the Stark conversion project that plans for additional enhanced outpatient program (EOP) beds for both general population (GP) and administrative segregation unit (ASU) inmates (hereafter referred to as the Stark EOP conversion project), and the DeWitt conversion project, reflect "activation" dates in 2013 or 2014, with patient admissions not completed at any of these sites until 2014. For the reasons set forth *infra*, the court will not approve the Stark EOP conversion project at this time. The special master reports that the mental health crisis bed project proposed for Stark is adequate and recommends its approval. That will be the order of the court. The CCC and the DeWitt conversion project will be approved subject to submission within thirty days of new activation schedules that reflect patient admissions completed to full occupancy for each of these projects by 2013.[2]

With respect to the Stark EOP conversion project, the papers before the court give rise to a concern that this project may not be sufficient to meet the needs of the plaintiff class. The special master reports that this project will require either an increase in the amount of out of cell time for class members housed in that program, or reduction in the number of admissions, or some combination of the two. Defendants report that they "expect[] to double cell up to 141% capacity" in the EOP program at Stark. Declaration of Deborah Hysen in Support of Defendants' Responses to Plaintiffs' Response to Defendants' Long-Range Mental Health Bed Plan and Request for Evidentiary Hearing, filed December 11, 2009, at ¶ 11. The three judge court has ordered defendants to "reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity" as a necessary prerequisite to the provision of constitutionally adequate medical and mental health care. *See* Opinion and Order filed Aug. 4, 2009. This court will not approve the Stark EOP conversion project as long as the project calls for a projected population in excess of 137.5% of the facility's design capacity. Defendants will be directed to file, within forty-five days, an amended proposal for the Stark EOP conversion project that limits the population accordingly and that meets the concerns for this project identified by the special master.

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[1] Defendants also refer to this facility as the Consolidated Care Facility (CCF). *See* Cover Sheet to Exhibit # 1 to defendants' Long-Range Mental Health Bed Plan.

[2] In their December 11, 2009 response, defendants represent that on December 7, 2009, the California Department of Finance authorized the California Department of Corrections and Rehabilitation to use a procurement process for the CCC that will enable defendants to complete patient admissions to the CCC by December 24, 2013. Defendants' Response, filed December 11, 2009, at 5.

Finally, defendants have failed to provide a detailed plan to meet the identified need for the female EOP population. Defendants' plan is described generally as a plan to convert existing inmate housing to EOP beds, and defendants represent that they are "currently working with the *Plata* Receiver on a health care improvement program at the three women's institutions to determine how best to meet" the needs of this female inmate population. Defendants also indicate that they anticipate that "any parole, sentencing, and/or credit reforms, and the Three-Judge Court's prisoner release order, will significantly impact the female population." Defendants' Long-Range Plan, filed Nov. 6, 2009, at 10. The court will consider proposed revisions to the long-range plan should reductions in the inmate population warrant such consideration. Until the population is reduced, however, defendants will be required to comply with this court's orders concerning long-range planning. For that reason, defendants will be directed to file, within forty-five days, a detailed plan with activation schedules to meet the long-range bed needs of female EOP inmates identified in the Navigant 2009 spring population projections.

Defendants include in their long-range bed plan a request for approval of their plan to replace two court-ordered projects, the Salinas Valley State Prison (SVSP) 72-Bed EOP-ASU project and the SVSP 96-Bed EOP-GP Treatment and Office Space and Housing Unit Conversion Project, with one project identified as the SVSP 300 EOP-GP Treatment and Office Space A-Quad Project. Defendants' request will be granted.

Finally, the special master reports that the parties have agreed that defendants should not be required to describe departures from timeframes, as required by paragraph 2 of the court's June 18, 2009 order, or to report impediments to timely completion of a project, as required by paragraph 6 of the court's September 24, 2009 order, unless a departure or an impediment will delay completion of a project by more than thirty days. That interpretation is hereby approved for both the June 18, 2009 order and the September 24, 2009 order, and incorporated in the requirements of this order, *infra*.

In accordance with the above, IT IS HEREBY ORDERED that:

1. All projects in defendants' long-range plan, including the mental health crisis bed project at Stark, are approved with the following exceptions:

a. Defendants' proposed Consolidated Care Center is approved subject to submission within thirty days of a new activation schedule for this project that reflects patient admissions completed to full occupancy by 2013.

b. Defendants' proposed DeWitt conversion project is approved subject to submission within thirty days of a new activation schedule for this project that reflects patient admissions completed to full occupancy by 2013.

c. Defendants' proposed Stark EOP conversion project is not approved. Within forty-five days from the date of this order, defendants shall file an amended proposal for the Stark EOP conversion project that limits the population for that facility to no more 137.5% of the facility's design capacity and that meets the concerns identified by the special master.

d. Defendants have not adequately described their plan to meet the projected needs of the female EOP population. Within forty-five days from the date of this order defendants shall file a detailed plan with activation schedules to meet the long-range bed needs of female EOP inmates identified in the Navigant 2009 spring population projections.

2. Beginning on March 1, 2010, defendants shall report to the special master on a monthly basis all action taken on each project and whether each project remains on schedule or has been or can be ac-

celerated. Defendants' report shall be in the form of updates to the activation schedules for these projects. For any project that has departed from the promised timeframes defendants shall describe with specificity the reason or reasons for the departure and shall identify individuals or agencies whose acts or failures to act contributed to the departure. These projects shall be reviewed quarterly in conjunction with the court-ordered projects approved by this court on June 18, 2009.

3. Defendants are not required to describe departures from timeframes, as required by paragraph 2 of the court's June 18, 2009 order and paragraph 2 of this order, or to report impediments to timely completion of a project, as required by paragraph 6 of the court's September 24, 2009 order, unless a departure or an impediment will delay completion of a project by more than thirty days.

4. Defendants' request to replace the two court-ordered projects, the SVSP 72-Bed EOP-ASU project and the SVSP 96-Bed EOP-GP Treatment and Office Space and Housing Unit Conversion Project, with one project identified as the SVSP 300 EOP-GP Treatment and Office Space A-Quad Project is granted. The provisions of this court's June 18, 2009 order that governed the replaced projects shall apply in full to the new project.

5. Plaintiffs' request for evidentiary hearing is denied.

DATED: January 4, 2010

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28
UNITED STATES CODE

No. 2:90-cv-00520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

To: Three-Judge Panel

Notice is hereby given that Defendants Arnold Schwarzenegger, John Chiang, Ana J. Matosantos, Matthew Cate, and Stephen W. Mayberg appeal to the Supreme Court of the United States from the January 12, 2010 Order of the Three-Judge Court, which imposed injunctive relief under the Prison Litigation Reform Act ("PLRA"). *See* 18 U.S.C. § 3626(a)(3), (g)(4). This appeal is taken pursuant to 28 U.S.C. § 1253.

As previously explained, the three-judge court was improperly convened under the PLRA and its January 12, 2010 order imposing injunctive relief, like its previous order of August 4, 2009, violates the PLRA.

Moreover, after the Three-Judge Court rejected the State's September 18, 2009 plan to reform the prisons and safely reduce the prison population over time, on November 12, 2009, the State submitted a revised plan to the Court that complied with the strict parameters of the Court's order to reduce the prison population to 137.5% of design capacity within two years. But the State emphatically pointed out that it could not implement the revised plan without waivers of state laws, and in response to the Court's order, the State identified which state laws the Court would need to waive for the State to implement the revised plan.

The Court on January 12, 2010 issued its "Order to Reduce [the] Prison Population," but the Court did not adopt any of the specific measures or requested state law waivers identified in the State's revised plan. (1/12/10 Order, *Plata* Dkt. No. 2287, *Coleman*

Dkt. No. 3767 at 3.) Instead, it again ordered the State to reduce its prison population to 137.5% of design capacity in six month increments over a two-year period. The Court stated that such an order "would afford the State maximum flexibility in its efforts to achieve the constitutionally required population reduction." (*Id.* at 3:1-2.) However, the Court did not provide the State with the requested state law waivers needed to implement its revised plan and meet these benchmarks. Specifically, the Court did not give the State authority to accelerate prison construction and operate private prisons, did not expand the State's ability to transfer inmates out of state, did not permit the State to implement the alternative custody program, and did not preclude CDCR from admitting certain inmates.

For these reasons, the State appeals from the Court's January 12, 2010 order.

DATED: January 19, 2010 HANSON BRIDGETT LLP

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DATED: January 19, 2010 EDMUND G. BROWN JR.
Attorney General of the
State of California

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
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Moreover, after the Three-Judge Court rejected the State's September 18, 2009 plan to reform the prisons and safely reduce the prison population over time, on November 12, 2009, the State submitted a revised plan to the Court that complied with the strict parameters of the Court's order to reduce the prison population to 137.5% of design capacity within two years. But the State emphatically pointed out that it could not implement the revised plan without waivers of state laws, and in response to the Court's order, the State identified which state laws the Court would need to waive for the State to implement the revised plan.

The Court on January 12, 2010 issued its "Order to Reduce [the] Prison Population," but the Court did not adopt any of the specific measures or requested state law waivers identified in the State's revised plan. (1/12/10 Order, *Plata* Dkt. No. 2287, *Coleman* Dkt. No. 3767 at 3.) Instead, it again ordered the State to reduce its prison population to 137.5% of design capacity in six month increments over a two-year period. The Court stated that such an order "would afford the State maximum flexibility in its efforts to achieve the constitutionally required population reduction." (*Id.* at 3:1-2.) However, the Court did not provide the State with the requested state law waivers needed to implement its revised plan and meet these benchmarks. Specifically, the Court did not give the State authority to accelerate prison construction and operate private prisons, did not expand the State's ability to transfer inmates out of state, did not permit the State to implement the alternative custody program, and did not preclude CDCR from admitting certain inmates.

For these reasons, the State appeals from the Court's January 12, 2010 order.

DATED: January 19, 2010 HANSON BRIDGETT LLP

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Attorney General of
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APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED
OF THREE JUDGES PURSUANT TO
SECTION 2284, TITLE 28 UNITED STATES CODE

No. 2:90-cv-00520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
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No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

DEFENDANTS' RESPONSE TO THREE-JUDGE COURT'S OCTOBER 21, 2009 ORDER

To: Three-Judge Court

In its order dated October 21, 2009, this Three-Judge Court rejected Defendants' September 18, 2009 Population Reduction Plan and ordered Defendants to submit a new population reduction plan that complies with the Three-Judge Court's August 4, 2009 Order. Specifically, Defendants were ordered to create a new plan that "provides for a reduction of the prison population to 137.5% of design capacity within two years." (Oct. 21, 2009 Order at 2:24-25.) In addition, the October 21, 2009 Order also requires Defendants to respond to several inquiries by the Court relating to: (1) the calculations with respect to Defendants' proposed population reduction measures included in the new plan; (2) the effect, if any, of the September 17, 2009 California Department of Corrections and Rehabilitation's (CDCR) reduced budget in rehabilitation programs; (3) measures the State will take to ensure public safety through reentry and diversionary programs; and (4) Governor Schwarzenegger's budget proposal submitted to the California State Legislature aimed at addressing California's historic budget deficit that could provide for a population reduction of up to 37,000 inmates.

As required by the Three-Judge Court's October 21, 2009 Order, Defendants submit the following documents:

1. Attached as Exhibit A is "State Defendants' November 12, 2009 Response to the Court's October 21, 2009 Order to Reduce Prison Population to 137.5% of Design Capacity" (Defendants' Response).

2. Attached as Exhibit B is the declaration of Jay Atkinson, Research Manager II for the Estimates and Statistical Analysis Section, Offender Information Services Branch,

CDCR. Mr. Atkinson's declaration is responsive to the Three-Judge Court's first inquiry regarding the calculations through which Defendants obtained the estimates of the population reductions associated with the proposed actions in Defendants' Response.

3. Attached as Exhibit C is the declaration of David Lewis, Deputy Director, Fiscal Services for CDCR. Mr. Lewis's declaration is similarly responsive to the Three-Judge Court's first inquiry regarding the calculations through which Defendants obtained the estimates of the population reductions associated with the proposed actions in Defendants' Response. Mr. Lewis's declaration is also responsive to the Three-Judge Court's second inquiry regarding whether the September 17, 2009 CDCR budget reduction of $250 million in rehabilitation programs will affect any estimated reductions included in Defendants' Response, to the extent Defendants' Response relies on rehabilitation programs. Lastly, Mr. Lewis's declaration is responsive to the Three-Judge Court's fourth inquiry regarding Governor Schwarzenegger's budget proposal previously submitted to the California Legislature that called for a reduction of up to 37,000 inmates over a two-year period aimed at addressing California's historic budget deficit.

4. Attached as Exhibit D is the declaration of Scott Kernan, Undersecretary of Operations for CDCR. Mr. Kernan's declaration is responsive to the Three-Judge Court's first

inquiry regarding the calculations through which Defendants obtained the estimates of the population reductions associated with the proposed actions in Defendants' Response.

5. Attached as Exhibit E is the declaration of Sharon Aungst, Chief Deputy Secretary of the Division of Correctional Health Care Services for CDCR. Ms. Aungst's declaration is responsive to the Three-Judge Court's second inquiry regarding all budget reductions, announced or implemented in 2009, that affect CDCR's provision of medical or mental health services and otherwise affect the size of the inmate population.

6. Attached as Exhibit F is the declaration of Robert Ambroselli, Acting Director, Division of Adult Parole Operations for CDCR. Mr. Ambroselli's declaration is responsive to the Three-Judge Court's third inquiry regarding the specific measures that the State will take to ensure public safety through reentry and diversionary programs, including a catalogue of current programs.

7. Attached as Exhibit G is the declaration of Elizabeth Siggins, Acting Chief Deputy for Adult Programs, CDCR. Ms. Siggins's declaration is similarly responsive to the Three-Judge Court's third inquiry regarding the measures that the State is taking to support and assist counties and other community-level providers of rehabilitation and reentry programs and of any steps it will take or has taken to increase, reduce, or eliminate support or assistance.

The submission of the attached Defendants' Response and declarations, as required by the Three-Judge Court's October 21, 2009 Order, is not an admission that this Court's order meets the requirements of the Prison Litigation Reform Act (PLRA). Nor is the submission of the attached documents an admission that Defendants' September 18, 2009 Population Reduction Plan was not in compliance with this Court's August 4, 2009 Order.

As will be argued in the U.S. Supreme Court, the Three-Judge Court erred in its rulings and orders. Thus, the submission of these attachments, including Defendants' Response, does not constitute waiver of any issue previously raised before this Court and which may be raised in the U.S. Supreme Court, including, but not limited to, whether the Three-Judge Court was properly convened; whether the Three-Judge Court misconstrued the PLRA's requirement that crowding is the primary cause of the violation of a federal right; whether the population cap of 137.5% of design capacity satisfies PLRA's "least intrusive" and "narrowly drawn" requirements; and whether the Three-Judge Court improperly refused to permit the State from introducing evidence "relevant only to determining whether the constitutional violations found by the *Plata* and *Coleman* courts were 'current and ongoing.'" (Aug. 4, 2009 Opinion and Order, at 54 fn. 42.)

DATED: November 12, 2009 HANSON BRIDGETT LLP

By: /s/ Paul B. Mello
PAUL B. MELLO
Attorneys for Defendants
Arnold Schwarzenegger, et al.

DATED: November 12, 2009 EDMUND G. BROWN JR.
Attorney General of
the State of California

By: /s/ Kyle Lewis
KYLE LEWIS
Deputy Attorney General
Attorneys for Defendants
Arnold Schwarzenegger, et al.

EXHIBIT A

State of California—
Department of Corrections and Rehabilitation
Arnold Schwarzenegger, Governor

OFFICE OF LEGAL AFFAIRS
Benjamin T. Rice
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

[LOGO]

November 12, 2009

Mr. Paul Mello
Hanson Bridgett LLP
425 Market Street
San Francisco, CA 94244-2550

Dear Mr. Mello:

Attached please find Defendants' response to the October 21, 2009, Three-Judge Court Order.

Sincerely,

/s/ Benjamin T. Rice
BENJAMIN T. RICE
General Counsel, Office of Legal Affairs
California Department of Corrections
and Rehabilitation

Attachments

STATE DEFENDANTS' NOVEMBER 12, 2009 RESPONSE TO THE THREE-JUDGE COURT'S OCTOBER 21, 2009 ORDER TO REDUCE PRISON POPULATION TO 137.5% OF DESIGN CAPACITY

BACKGROUND AND SUMMARY OF RESPONSE

On August 4, 2009, this Court ordered the State to produce a prisoner reduction plan that would, within two years, reduce the State's prison population to 137.5% of design capacity—i.e., a reduction of more than 40,000 prisoners over a two-year period.[1] Defendants subsequently presented the Three-Judge Court with a plan to safely reduce the State's prison population over time. It did not achieve the prisoner reduction that the Court desired on the timeframe the Court ordered, because the State's plan (the September 18, 2009 Plan) reflected the State's goal to implement long-term prison reform that enhanced public safety and reduced the prison population. Although the State's plan significantly reduced the prison population over time while the number of State prisoners was projected to increase, to be sure, this plan was not designed as a short-term fix for prison crowding. But the Court rejected the State's plan and ordered the State to present a new plan that, "most important, provides for a reduction of the prison population to 137.5% of design capacity within two years."

Without waiving any appellate rights, conceding the appropriateness of the Three-Judge Court's prior rulings and findings, or admitting that the prisoner release order issued by the Three-Judge Court can be implemented without substantially adversely impacting public safety and the operation of the criminal justice system, Defendants submit this Response as required by the Three-Judge Court's October 21, 2009 order to meet the court-selected population figure of 137.5% of design capacity for California's prisons by the end of 2011.

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[1] Based on the evidence at the time of trial, the Three-Judge Court estimates the prisoner reduction to be approximately 46,000 inmates. Because the actual prison population fluctuates over time, the estimated reduction does as well.

In this Response to the Three-Judge Court's October 21, 2009 order, Defendants continue to propose the following items from their September 18, 2009 Plan, for which they already had the authority through legislation or executive or administrative powers:

1. Pre-Custody Reforms: California Community Corrections Performance Incentives Act of 2009.
2. In-Custody Reforms: Credit-Earning Enhancements.
3. Parole Reforms: (a) "Summary Parole;" (b) Parole Violation Decision Making Instrument; and (c) Reentry Courts.
4. Administrative Changes: (a) California Out-of-State Correctional Facility Expansion; (b) Community Correctional Facilities Utilization; (c) Commutations of Sentences; (d) Discharge of Deported Parolees; and (e) Alternative Sanctions for Violations of Parole.
5. Increased capacity through construction of new infill projects, healthcare projects, conversion of former Division of Juvenile Justice sites, and reentry projects.

Several of the reforms identified above were recently enacted by the State's executive and legislative branches. Moreover, the Defendants committed in their September 18, 2009 Plan, and remain committed now, to seeking additional State law changes through the State Legislature. Nonetheless, in rejecting the State's September 18, 2009 Plan, the Court ordered the State to identify State laws that limit the Defendants' ability to implement population reduction measures, and suggested that it might waive State laws to achieve the reduction it desires. Although the Defendants have complied with the Court's order, they do not believe it is appropriate for this federal Court to waive State laws. However, the prisoner reduction that this Court seeks—a reduction of more than 40,000 prisoners in two years—can only be accomplished if the State Legislature enacts new laws and/or this Court orders changes to State laws, as discussed in this Response. Thus, Defendants present the following proposals to reach the court-ordered population figure of 137.5% of design capacity within two years. Some of these proposals were included in the September 18, 2009 Plan, but the State Defendants had no ability to implement them at that time absent additional legislation or court orders:

1. Additional inmates housed in out-of-state facilities.
2. Changing of property crime thresholds.
3. Establishing alternate custody options for low-risk offenders.
4. Accelerating construction projects under AB 900.

5. Additional use of private in-state facilities.
6. County jail time for enumerated felonies.

The following discussion contains two sections: (1) a section discussing the proposals from the September 18, 2009 Plan that require no additional legislation or court orders; and (2) a section discussing the additional proposals, some of which were originally included in the September 18, 2009 Plan, that require either legislation or court orders to accomplish. The Table at the end of this Response sets forth the population reduction figures in six-month increments as required by the Three-Judge Court's order. In general, these estimates represent CDCR's best effort to project future impacts to a population that is dynamic and will change in ways that are not known today. Submitted concurrently with this Response are declarations addressing the Court's questions posed in its October 21, 2009 Order.

SECTION ONE

PROPOSALS FROM THE SEPTEMBER 18, 2009 PLAN THAT REQUIRE NO ADDITIONAL LEGISLATION OR COURT ORDERS TO IMPLEMENT

Defendants maintain that the September 18, 2009 Plan is the most effective way to safely and responsibly reduce its population and the elements of that plan are the foundation for this Response. Below, Defendants summarize the proposals of the September 18, 2009 Plan and address the questions from the Three-Judge Court's October 21, 2009 order. (Other answers are in the concurrently-filed declarations.) Specifically, this Court directed Defendants to set forth effective dates and to estimate reductions in population expected after six, twelve, eighteen, and twenty-four months after implementation. (Oct. 21, 2009 Order at 2:25-28.) Also, this Court ordered Defendants to "(1) explain the calculations through which they obtained the estimates of the population reductions associated with each action that they propose; (2) identify the assumptions underlying those calculations; and (3) explain why those assumptions are reasonable." (*Id.* 3:2-5.)

To respond to the Three-Judge Court, Defendants submit a Table that estimates the impact of the proposals in six month increments. As demonstrated in the Table, there will be a period of time during which Defendants will ramp up the programs and therefore it appears as though there is a delayed realization of the population reduction.

For each eligible number, in generating estimates of the impact on the reduction in average daily population (ADP), Defendants generated estimates based on eligible populations and factored in a ramp-up period, overlap with other programs, etc., in an attempt to obtain the most reasonable and reliable population reduction estimates. For the population reduction measures, CDCR chose to conservatively estimate the impact in order to pick the most reliable and achievable numbers. (*See* generally Decl. of Jay Atkinson describing the methodology employed by CDCR in calculating its population reduction estimates, filed concurrently.)

I.

LEGISLATIVE AND ADMINISTRATIVE REFORMS

A. PRE-CUSTODY REFORMS: California Community Corrections Performance Incentives Act of 2009

The recent passage of Senate Bill 18 (SB 18)[2] creates a system of rewards for probation success by establishing the California Community Corrections Performance Incentives Act of 2009. The community corrections program created by this act will authorize counties to receive funding for implementing and expanding evidence-based programs for felony probationers. Counties will be required to track specific probation outcomes and, depending on the success of those outcomes, may be eligible for "probation failure reduction incentive payments" or "high performance grants." The new funding model created by SB 18 will sustain funding for improved, evidence-based probation supervision practices. By incentivizing probation success, California will lower the number of probationers sent to prison each year.

Defendants estimate this program will net an approximate 1,915 reduction in CDCR's ADP by December 31, 2011. Defendants were able to estimate this reduction by utilizing information in CDCR's Offender Information Services Branch's (OISB) data warehouse. CDCR's OISB compiles and retains summary statistical information about inmates and parolees. The OISB data reflected that CDCR receives approximately 19,150 new admissions as a result of felony probation revocations in a calendar year. CDCR then made the assumption that the average return for revocation was one year and took the conservative estimate that this program would have a ten percent success rate.

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[2] Sen. Bill No. 18 (2009 3d Ex. Sess.). The third extraordinary legislative session ended on October 26, 2009. These proposals become law and operative on January 25, 2010.

B. IN-CUSTODY REFORMS: Credit Earning Enhancements

The passage of SB 18 also provides a number of credit earning enhancements. First, it provides one day of sentence credit for every day served in county jail from the time of sentencing. Prior to the passage of SB 18, the law provided one day of credit for every two days served in county jail. Second, it provides eligible inmates up to six weeks of credit per year for completion of approved programs. This approach to incentivizing good behavior for program completions has been suggested by several experts, including in the Expert Panel Report. Third, it provides that all parole violators returned to custody who are otherwise eligible should receive one day of credit for each day served. Prior to the new law, only some violators received such credit. Fourth, it provides two days of credit for every one day served once the inmate is endorsed to transfer to a fire camp, rather than providing such credit only after the inmate actually participates in the camp. Finally, it provides a consistent rule of one day of credit for every day served for all eligible inmates, whether those inmates are on a waiting list for a full-time assignment, participating in college, or undergoing reception center processing, so long as the inmate is discipline-free during that time. Previously, the law provided a similar credit structure, but did so through the existence, for example, of a "bridging program," whereby inmates in reception centers sign up for self-study programs and receive credit. This legislation makes credit earning consistent while obviating the need for a bridging program.

Defendants estimate this program will net an approximate 2,921 reduction in CDCR's ADP by December 31, 2011. The reduction in ADP for this proposal at the six, twelve, eighteen and twenty-four month mark can be found on Table 1. Defendants estimated the ADP reduction for this legislation by utilizing data at CDCR's OISB. CDCR has a simulation model that is used to create population projections for the future. This particular proposal is one that can use the simulation model to determine a net effect on the population on a month by month basis. Insofar as this proposal overlaps the proposal to house individuals in county jail who are convicted of certain enumerated offenses, CDCR discounted the reduction from this proposal by 15%.

C. PAROLE REFORMS

1. "Summary Parole"

The enactment of SB 18 creates a new program of "summary parole" whereby CDCR is prohibited from returning to prison, placing a parole hold, or reporting to the Board of Parole Hearings, any parolee who meets all of the following conditions: (1) is not a sex offender;[3] (2) has not been committed to prison for a sexually violent offense;[4] (3) has no prior conviction for a sexually violent offense; (4) has no instant or prior convictions that are violent[5] or serious;[6] (5) has not been found guilty of a serious disciplinary offense as defined by CDCR during his or her current term of imprisonment; (6) is not a validated prison gang member or associate, as defined in CDCR regulations; (7) has not refused to sign any written notification of parole requirements or conditions; and (8) has not been determined to pose a high risk to reoffend pursuant to a validated risk assessment tool.[7] Other offenders will be subject to traditional parole supervision upon release from prison.

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[3] California Penal Code, § 290, et seq. Subsequent references will be to the Penal Code unless otherwise noted.

[4] California Welfare and Institutions Code, section 6600(b).

Defendants anticipate that "summary parole" will reduce CDCR's institutional population because, when fully implemented, CDCR will be precluded from revoking parole and returning low risk parolees to prison for parole violations.

Defendants estimate this program will net an approximate 4,556 reduction in CDCR's ADP by December 2011. Defendants estimated the 4,556 reduction in ADP by first identifying the total number of adult parolees in 2008 that were non-serious, non-violent, non-sex offenders, with no prior serious or violent offenses, which was converted to a percentage and applied to the Spring 2009 Population Projections number of parolees to give an updated number of applicable parolees. Then using data from OISB, the percentage of this population that were low and moderate risk were applied to estimate the applicable parole population. Then it was assumed that a like percentage of the total number of parole violators who return to custody (PV-RTC) would not go to prison, and this determined the total expected prison ADP reduction. Then it was assumed that it would take approximately five months for the total impact of the ADP reduction to be realized so that was calculated to reduce the ADP in 2009-10. The 4,556 number is based on the best knowledge available at the time. Of course, actual implementation may vary from these numbers. Factors that could not be accounted for include: 1) crimes that do not show up on OBIS such as those committed in other states that may render an individual ineligible; and 2) changes in local prosecutorial behavior resulting in some of these offenders coming to prison with a longer sentence as a parole violator with a new term (PV-WNT).

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[5] § 667.5 (c).

[6] § 1192.7 (c).

[7] CDCR intends to employ the California Static Risk Assessment tool, a validated tool that predicts an offender's risk to reoffend on the basis of static information received from CDCR and the California Department of Justice.

2. The Parole Violation Decision Making Instrument

Senate Bill 18 requires that CDCR employ a parole violation decision making instrument (PVDMI) to determine the most appropriate sanctions for parolees who violate conditions of parole. As stated in more detail in the September 18, 2009 Plan, the PVDMI is an effective tool in placing parolees in the right programs and returning the high risk parole violators to prisons thereby increasing public safety while decreasing recidivism.

At this time, CDCR does not have sufficient information upon which to base a reduction in population. However, the decision making instrument has produced uniform, policy driven responses to violations of parole. In this way, CDCR can effect a cultural change at the field level to afford security to field staff that the CDCR administration supports and encourages the use of interim sanctions in response to violations of parole. It is too early in its implementation to identify a drop in returns to custody at this time though CDCR is hopeful that it will begin to see the impact of this policy in the near future.

3. Reentry Courts

Senate Bill 18 also authorizes CDCR to collaborate with the California Administrative Office of the Courts to establish and expand drug and mental health reentry courts for parolees. These reentry courts will provide an option for parolees with drug and mental health needs to receive highly structured treatment in the community, under the close supervision of their parole agent and the court, rather than being returned to prison for violations that may be related to those needs. The legislation provides that for participating parolees, the court, with the assistance of the parolee's parole agent, "shall have exclusive authority to determine the appropriate conditions of parole, order rehabilitation and treatment services to be provided, determine appropriate incentives, order appropriate sanctions, lift parole holds, and hear and determine appropriate responses to alleged violations."

The implementation of the reentry courts may have a significant impact on reducing the number of mentally ill inmates in CDCR because it should reduce the number of parolees with mental illness returning to prison.

Defendants anticipate a reduction of 435 ADP by December 2011. This ADP estimate was developed during the budget process, and it was associated with a $10 million budget reduction. CDCR does not have any additional information to provide on how effective this program will be in reducing returns to custody.

D. ADMINISTRATIVE CHANGES

1. California's Out-of-State Correctional Facility Expansion

Defendants will expand the California Out-of-State Correctional Facility (COCF) program, which has as its primary purpose removing non-traditional beds and relieving crowding by transferring CDCR inmates to contracted out-of-state facilities. The COCF program was established in October 2006 under the Governor's Prison Overcrowding State of Emergency Proclamation. Assembly Bill 900 similarly authorized CDCR to transfer inmates out of state, but imposed additional restrictions on the transfer of inmates with medical and mental health conditions. CDCR currently maintains approximately 8,000 inmates in out-of-state facilities. Beginning in approximately February 2010, the COCF program will expand and CDCR has signed contracts to include up to 2,416 new Level III beds. By approximately January 2011, CDCR anticipates housing a total of 10,468 inmates at out-of-state facilities. The COCF program has been tremendously successful.

2. Community Correctional Facilities Utilization

Defendants intend to better utilize existing private Community Correctional Facilities (CCFs) in California to assist in the reduction of the prison population. CDCR established thirteen CCFs throughout California to house low-level inmates. CCFs prepare these inmates for their return to the community on parole. Robust oversight of the CCFs is already in place. However, CCFs have been underutilized by CDCR in the past, primarily because appropriate male inmates are also eligible for other types of housing, including minimum security facilities and camps. Yet, there appears to be an abundance of female inmates who are eligible for placement into these facilities.

Accordingly, CDCR recently closed three of these male facilities. The Information for Bid (IFB) will be sent out on or about January 27, 2010, with the last day for bidders' letters of inquiry on February 12, 2010.

Defendants estimate this program will net an approximate 800 inmate reduction by December 31, 2011.

3. Commutations of Sentence

The Governor will review cases of certain deportable inmates under his discretionary constitutional clemency authority. A commutation of sentence would result in an inmate's release from State custody into federal custody and deportation.

Defendants estimate this program will reduce CDCR's ADP by approximately 600 by December 31, 2011.

4. Discharge of Deported Parolees

Earlier this year CDCR implemented a new policy to discharge from parole the over 12,000 criminal aliens who have served their full state prison sentences and, upon release to parole, have been deported by the federal government. Previously, California had retained those criminal aliens on parole, even after their deportation. Under CDCR's new policy, those parolees have been discharged and additional parolees will be discharged from parole on an ongoing basis as CDCR receives confirmation of their deportation from the federal government. This new policy has resulted in fewer parolees being returned to state prison for parole violations and provides an incentive for federal prosecution of these offenders.

This proposal was in effect earlier this year and was accounted for in the new Fall 2009 Population Projections set forth in the Table at the end of this Response. Accordingly, the numbers previously stated in the September 18, 2009 Plan (at pp. 14, 19.) are not set forth separately in the Table.

5. Alternative Sanctions for Violations of Parole

CDCR will make greater use of electronic monitoring systems such as global positioning systems (GPS), for parole violators in lieu of revocation and re-incarceration. The expanded use of GPS and other electronic monitoring systems will permit CDCR to monitor those offenders outside of state prison for parole violations.

Defendants estimate this program will net an approximate 1,000 reduction in CDCR's ADP by December 31, 2011. This reduction reflects an assumption that CDCR will begin diverting offenders in March 2010, and that it will be able to acquire 300 GPS units per month until September 2010, when there will be 2,000 units in use. If the system truly diverted inmates for every day they would have otherwise spent in prison, the reduction in ADP would actually be 2,000. The 50% discount assumes that there will be processing time between offenders that wear the device and that, on average, a revocation action to prison would have been shorter than the time given to an inmate to wear GPS as a sanction.

II.

INCREASED CAPACITY

Assembly Bill 900 (AB 900) was passed by a bipartisan Legislature and signed into law by Governor Schwarzenegger on May 3, 2007. AB 900 allocates $7.6 billion, of which $6.4 billion is designed to reform CDCR by reducing prison overcrowding, increasing rehabilitation programs, and providing more beds for all inmates, including those requiring medical and mental health care. AB 900's comprehensive plan immediately relieved overcrowding by providing for additional out-of-state transfers. AB 900 also provides for new rehabilitation programs and reentry facilities to ease parolees' transition back into California communities, thereby reducing recidivism, relieving prison overcrowding, and ensuring public safety.

The descriptions below are almost entirely the same as was presented to this Court in the State's September 18, 2009 Plan. Where numbers or timelines have changed, Defendants identify the discrepancy for the relevant project(s).

A. INFILL PROJECTS

Construction projects will result in new annex housing units and renovation of existing facilities. These projects will add bed capacity as well as additional office and treatment space to relieve operational pressures throughout CDCR institutions.

Newly constructed facilities are planned in standalone units and will operate semi-autonomously from the main institutions, though some space and/or functions, such as administrative services, may be shared by the main institutions to ensure the newly constructed facilities are fully serviced. Each newly constructed facility will have appropriate programming space and staffing for the population to be served.

Renovated facilities primarily represent current or former juvenile correctional facilities that are being repurposed to serve an adult male population. All renovated facilities will also provide for the reduction of nontraditional beds, and will have the requisite amount of programming space and staff for their intended populations. A description of each project follows by phase of funding as outlined in AB 900.[8] There are a few projects that are not funded through the AB 900 appropriation and those projects are noted.

1. *Kern Valley State Prison*

This project will result in 930 new beds in a Level IV semi-autonomous facility at the existing Kern Valley State Prison site, with the addition of five housing units on 33 acres using the 270 design celled-bed prototype. This construction will include space for rehabilitative programming (i.e., vocational, academic, substance abuse), work opportunities, and a health services building of approximately 22,000 square feet. A portion of these beds will be wheelchair-compliant beds.

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[8] CDCR is currently pursuing legislation to redirect $1 billion from its infill funding appropriation under AB 900 to the healthcare funding appropriation. The time lines set forth in this Response may change depending upon passage of that legislation. In addition, Defendants anticipate funding the proposed Consolidated Care Facility with the $1 billion in funds redirected from the infill appropriation.

This project will be submitted to the Joint Legislative Budget Committee (JLBC) for its approval in early 2010 with a request for State Public Works Board (PWB) approval and interim financing from the Pooled Money Investment Board (PMIB) to immediately follow. Necessary environmental impact review (EIR) documents are already underway. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2012-2013.

2. *Reception Center—Southern California*

This project will result in 943 new beds in a cell-design semi-autonomous facility with five housing units, including the support space necessary to house reception center inmates. This project will also include a health services building to accommodate this population. Its location will be on the grounds of the California Institute for Men in Chino where CDCR's need for additional reception center beds is greatest. A portion of these beds will be wheelchair-compliant beds.

The Reception Center Prototype planning is being coordinated with the proposed renovation at the Heman G. Stark facility. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2012-2013.

3. *Wasco State Prison—Level IV Celled Facility*

This project builds a 1,896 bed Level IV semi-autonomous celled facility based on CDCR's 180-design prototype. This project includes eight housing units, with support and programming space planned for available land located on the unused land at the existing prison in Wasco. This project will also include a Correctional Treatment Center (CTC) to serve the population and a portion of the overall beds will be wheelchair-compliant.

This project is currently proposed for funding in Phase 2 of AB 900. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2012-2013.

B. DIVISION OF JUVENILE JUSTICE RENOVATIONS

1. *Heman G. Stark Conversion*

This project renovates an existing 1,200-cell Department of Juvenile Justice facility in Chino. It includes the installation of design elements necessary to house an adult male population (i.e., lethal electrified fence, guard towers, etc.), ADA improvements, expanded or new administrative support buildings, and a new health services building. This plan provides for double-celling a portion of the facility and envisions approximately 1,800 beds. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, 700 beds should come on line in or about December 2010, and 1,100 beds in or about June 2011.

The description above, submitted as a part of the September 18, 2009 Plan, differs slightly from the November 6, 2009 long-range bed plan submitted in the *Coleman* court. The September 18, 2009 Plan set out to establish the net gain of 1,800 beds to the adult male population. These beds are being phased into CDCR's design capacity based on the vacancy of DJJ's ward population at Stark. The November 6, 2009 *Coleman* filing, on the other hand, reflects that these beds will be renovated to provide bed and treatment space for a designated EOP and medical population and reflects only the number of beds specific to the *Coleman* population. These mental health beds will come on line in or about Fiscal Year 2013-2014. CDCR continues to work on developing the scope of this project with the *Plata v. Schwarzenegger* Receiver and the *Coleman* Special Master. The activation schedule submitted in the *Coleman* filing reflects full activation for the *Coleman* population.

2. *Department of Juvenile Justice Conversion—Paso Robles*

This project renovates a former juvenile justice facility located in Paso Robles. This facility currently includes both dorms and an existing 270-celled prototype. The intended capacity is approximately 899 beds which includes some double-celling of the population. This is intended for a general population facility with a health-care mission and will serve elderly inmates with healthcare needs. The scope of work would include a new lethal electrified fence to increase the security level of the facility from a Level I to a Level II, as well as building code updates, ADA improvements, and an expanded healthcare facility. A portion of these beds will be wheelchair-compliant beds.

This project is anticipated to be submitted to the JLBC in Fall 2009 for approval and will subsequently be submitted to the State PWB and the PMIB for approval and financing. The EIR document is already underway. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2012-2013.

3. *Department of Juvenile Justice Conversion—DeWitt*

This project renovates a former juvenile justice facility located in Stockton. The intended capacity is approximately 1,133 beds which includes some double-celling of the population. The facility is intended for a general population facility with a health care mission and will serve inmates with medical outpatient needs and inmates requiring Enhanced Outpatient Program mental health services. CDCR is consulting with the *Plata* Receiver to identify the appropriate scope for the project.

This project is currently proposed for funding in Phase 1 of AB 900. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2013-2014.

C. HEALTHCARE PROJECTS

The healthcare projects described below include renovation and expansion of existing facilities to add housing, office, and/or treatment space to further meet the healthcare needs of CDCR's adult inmates at its existing prisons. Several of these projects are being constructed pursuant to specific court orders. Also, many of these projects are being planned in consultation with the *Plata* Receiver.

1. *Northern Consolidated Care Facility*

This project provides for a large healthcare facility serving a medical and mental health population to include specialized housing, treatment, and support space at the site of the former Karl Holton Juvenile Correctional Facility in Stockton and for which an environmental document has been filed with the State Clearinghouse. This facility would provide approximately 1,722 new beds serving high acuity medical and mental health patients, including mental health crisis beds.

The population number and occupancy dates for this project have been refined since the September 18, 2009 Plan. The bed number has increased from 1,702 to 1,722 and the occupancy date for the project has been set out to Fiscal Year 2013-2014. The original schedule submitted in the September 18, 2009 Plan was predicated on the *Plata* Receiver's delivery method. The current schedule, however, is based on that authority currently maintained by CDCR for design bid/build approach to construction.

2. *San Quentin State Prison—Correctional Treatment Center (Building 22)*

This project is a renovation and replacement of the existing infirmary at San Quentin State Prison and will include a Correctional Treatment Center providing 41 medical and mental health beds. Assuming no obstacles arise, anticipated completion is in or about January 2010.

3. *California Men's Colony—Mental Health Crisis Beds*

This project builds a 50-bed mental health crisis facility on available land at the California Men's Colony in San Luis Obispo. This project scope and schedule are being coordinated with the Special Master in the *Coleman* case. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, Defendants anticipate first occupancy in these beds in August 2012 with full occupancy by October 2012 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

4. *California State Prison, Lancaster—Enhanced Outpatient Program*

This project builds additional treatment and office space to increase by 150 the number of Enhanced Outpatient Program mental health inmate patients served at California State Prison, Lancaster. This project's scope and schedule are being coordinated with the Special Master in the *Coleman* case. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, Defendants anticipate activation of this treatment and office space in July 2012 with full activation by mid September 2012 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

5. *California Medical Facility—Intermediate Care Facility*

This project builds a 64-bed Intermediate Care Facility to serve mental health patients on the grounds of the California Medical Facility. This project scope and schedule are being coordinated with the Special Master in the *Coleman* case. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about November 2012 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

6. *California Medical Facility—Enhanced Outpatient Program*

This project adds 67 Enhanced Outpatient Program—General Population beds and builds office and treatment space to serve 600 Enhanced Outpatient Program—General Population inmate-patients on the grounds of the California Medical Facility. This project's scope and schedule are being coordinated with the Special Master in the *Coleman* case. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about April 2013 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

7. *California State Prison, Sacramento—Enhanced Outpatient Program*

This project builds office and treatment space to serve 192 Enhanced Outpatient Program mental health inmate patients on the grounds of California State Prison, Sacramento. This project scope and schedule are being coordinated with the Special Master in the *Coleman* case. This project is not funded through AB 900. If requisite approvals are obtained, there are no legal challenges; and there are no construction delays, anticipated completion is in or about November 2011 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

8. *San Quentin State Prison—Condemned Inmate Complex Correctional Treatment Center*

This project builds 1,152 beds in a new Condemned Inmate Complex on the grounds of San Quentin. This project will include a 24-bed Correctional Treatment Center serving the medical and mental health needs of the inmate population. CDCR will submit this project for funding in Fall of 2009 and expects to award contracts and break ground in March 2010. This project is not funded through AB 900. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about Fiscal Year 2011-2012.

9. *Salinas Valley State Prison—Enhanced Outpatient Program*

Defendants identified two Salinas Valley State Prison (SVSP) projects in their September 18, 2009 Plan: 1) a 96-Bed Enhanced Outpatient Program—General Population (EOP-GP) project that would convert an existing housing unit to provide EOP-GP housing for 96 EOP-GP inmates, and would expand the existing mental health services building to provide the additional treatment and office space needed for this increased EOP-GP capacity;[9] and 2) a 72-bed EOP Administrative Segregation Unit (ASU) that would provide housing, treatment, and office space for 72 EOP-ASU inmate-patients.

After careful analysis and, in consultation with the *Coleman* Special Master as well as the *Plata* Receiver, CDCR determined that the most feasible alternative would be to replace the two SVSP projects with a new consolidated project that will provide treatment and office space for 300 inmate-patients.

This new project, known as the 300 EOP-GP Treatment and Office Space A-Quad Project, will require the design and construction of a new treatment and office building on "A" yard and the relocation of all EOP-GP inmate-patients to that yard. This project will result in 12 more EOP-GP beds than CDCR's previous plan.[10] The 72-bed EOP-ASU unit will stay in its current location; that is, Buildings D1 and D2.[11] The existing Mental Health treatment space located on Facility D will accommodate the 72-bed EOP-ASU unit, and thereby negate the need for construction of treatment space for that population.

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[9] This project was scoped to include the existing 192 EOP-GP inmate-patients, plus an additional 96 EOP-GP beds.

[10] The current EOP-GP Treatment and Office Space and Housing Unit Conversion Project is designed to provide treatment and office space for the existing 192 EOP-GP inmate-

On November 6, 2009, Defendants sought approval from the *Coleman* Court to replace the two SVSP court-ordered projects with the new SVSP 300 EOP-GP Treatment and Office Space A-Quad Project. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about October 2013.

10. *California Institute for Women—Psychiatric Services Unit*

This project intends to renovate existing housing at the California Institute for Women in Chino to provide housing and treatment for a 20-bed Psychiatric Services Unit serving the mentally ill offender population. This project scope and schedule are being coordinated with the Special Master in the *Coleman* case. This project is not funded through AB 900. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about February 2011 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

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patients, plus an additional 96 inmate-patients, for a total of 288 beds. The new 300 EOP-GP Treatment and Office Space A-Quad Project is designed to serve 300 inmate-patients, for an increase of 12 beds.

[11] The 72-bed EOP-ASU unit consists of 45 existing EOP-ASU beds as well as the 27 new beds that are part of Defendants' short-term bed plan filed on May 26, 2009, and which Defendants propose to make permanent.

11. *California State Prison, Sacramento—Psychiatric Services Unit*

This project provides office and treatment space to serve 152 Psychiatric Services Unit mental health inmate patients on the grounds of the California State Prison, Sacramento. This project scope and schedule are part of the construction projects proposed in the *Coleman* case.

If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about May 2013 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

12. *California State Prison, Corcoran—Enhanced Outpatient Program*

This project will add office and treatment space to serve an additional 45 Enhanced Outpatient Program mental health inmate patients on the grounds of California State Prison, Corcoran.

If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about April 2013 as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

13. *Southern California Crisis Beds*

This project will site a new 60-bed unit, 30 beds of which will be designed as mental health crisis beds, at the Heman Stark facility in Chino. These beds were to be located initially at the Consolidated Care Facility. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, these beds should come on line in or about Fiscal Year 2013, as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

14. *California Institute for Women—45 Bed Intermediate Care Facility*

This project will build a new 45-bed intermediate care facility at the California Institute for Women to serve the mental health population for female adults in the custody of CDCR. Preliminary plans are complete with this project and it is currently in the working drawings phase, with construction to be funded by AB 900 funds. The project scope and schedule are being coordinated with the *Coleman* Special Master. If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, anticipated completion is in or about March 2012, as reflected in the activation schedule submitted with the *Coleman* November 6, 2009 long-range bed plan.

D. REENTRY PROJECTS

Pursuant to AB 900, reentry projects provide for the design and operation of secure community reentry facilities located in communities throughout the state. These facilities will hold a maximum of 500 inmates who are within 6-12 months of being released. These facilities will be autonomous facilities and have been designed to facilitate an intensive rehabilitative programming environment and include healthcare treatment space for the population to be served.

To date, eleven counties have agreed to locate a reentry facility to serve their population. The first reentry facilities are being planned in the counties of

Kern, Madera, San Joaquin (to also serve Amador and Calaveras), San Luis Obispo (to also serve Santa Barbara and San Benito), and San Bernardino. A reentry facility planned for San Diego is currently being sited. Additional counties have expressed interest in supporting reentry facilities in their communities.

If requisite approvals are obtained, there are no legal challenges, and there are no construction delays, Defendants estimate this program will build approximately 500 beds in or about Fiscal Year 2010-2011, 500 additional beds in or about Fiscal Year 2012-2013, 1,500 additional beds in or about Fiscal Year 2013-2014, and 5,500 additional beds in or about Fiscal Year 2014-2015.

SECTION TWO

ADDITIONAL REFORMS THAT REQUIRE EITHER FURTHER LEGISLATION OR FEDERAL COURT ORDERS

The Administration has demonstrated its willingness to reform the State's prisons, and the Administration will continue to push for meaningful reforms like the reforms adopted in SB 18. The following measures, however, cannot be accomplished administratively, and they will require legislative changes or federal court orders. The Defendants believe that it is not appropriate for this Federal Court to effect State law changes, and that such changes should be implemented by the State's executive and legislative branches. Moreover, as the Defendants pointed out in the September 18, 2009 Plan, they believe that State law waivers are not permissible here.[12] Nonetheless, pursuant to the Court's October 21, 2009 order, Defendants now identify, wherever possible, State laws that, if waived or changed by federal court order, would allow the Defendants to implement additional reduction measures.

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[12] The Court's August 4, 2009 order stated, "[s]hould any of defendants' proposed population reduction measures require the

A. ADDITIONAL CALIFORNIA OUT-OF-STATE CORRECTIONAL FACILITY EXPANSION

In addition to the 2,416 bed expansion set forth above, Defendants will work with the Legislature to remove the existing clause that calls for the termination of the out-of-state program. The 2006 Prison Overcrowding State of Emergency Proclamation suspended the consent provisions of Penal Code section 11191. However, it is unclear the extent to which CDCR will be able to rely on the Emergency Proclamation in the future for out of state transfers, and section 11191, which becomes operative on July 1, 2011, makes clear that inmates must consent to out of state transfers. This Court could immediately

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waiver of any provisions of state law, the state shall so advise the court, and shall explain why the requested waiver is permissible under 18 U.S.C. § 3626(a)(1)(b)." The State's September 18, 2009 Plan pointed out that this Court did not permit Defendants to introduce evidence regarding whether there are any current and ongoing violations of federal rights. Plaintiffs were also not required to prove, nor did they prove, that there are any current and ongoing violations. Thus, the State Defendants continue to preserve their objection that state law waivers are impermissible here, because State Defendants believe that the statutory requirements authorizing such waivers have not been satisfied. Furthermore, because the recent improvements to healthcare and the plans set forth throughout this submission provide a form of relief correcting alleged federal violations, the State Defendants have not and do not affirmatively seek the waiver of any State law under the PLRA (*see* 18 U.S.C. § 3626(a)(1)(B)(ii)-(iii)).

and indefinitely waive the consent provisions in section 11191 to allow out of state transfers to continue uninterrupted. Additionally, this Court could immediately waive the provisions in section 11191 requiring attorney consultations, which entails a costly and time consuming process. The Court could also waive the provisions of section 11191 that restrict CDCR's ability to transfer out of state inmates with serious medical and mental health conditions, and inmates in the mental health delivery system at the Enhanced Outpatient Program level of care or higher. These waivers would allow CDCR to continue to transfer inmates out of state indefinitely, expand the pool of inmates eligible for transfer, and expedite the transfer process. They would also facilitate CDCR entering into additional contracts, or establishing long-term contracts, with out-of-state facilities willing to house CDCR inmates.

With these changes, State Defendants estimate they will be able to expand the out-of-state program by approximately 1,500 beds by December 31, 2011, reducing its ADP by that amount.

B. PROPERTY CRIME THRESHOLDS

Numerous property crimes in California are punishable alternatively as a misdemeanor or a felony, depending on the dollar amount of the taking. For example, grand theft is punishable as a felony when the amount stolen exceeds $400, but is punishable as a misdemeanor when the amount stolen is $400 or less. In most cases, the threshold for determining the type of sentence imposed was established over 20 years ago. As time has passed and inflation risen, increasing numbers of these wobblers have become prosecutable as felonies, thereby resulting in greater numbers of offenders eligible for prison sentences rather than jail sentences.

For thirty-nine of these property crimes, SB 18 increased the dollar threshold to present-day values. For example, property crimes where the threshold was set at $400 were increased to $950. The aim was to expose fewer offenders to felony prosecution and prison terms and thereby reduce the prison population. However, SB 18 left the threshold for grand theft itself unchanged, an omission that does not capture the impact of that offense, and also undermines the effect of having changed many other property crimes because they could alternatively be charged as grand theft. Defendants seek legislation to increase the threshold of grand theft to $950. If fully implemented, Defendants estimate this program will net an approximately 2,152 reduction in CDCR's ADP.

This is not a proposal for which a Court order could waive the appropriate change in state law as an affirmative action is required. Absent additional legislation, Defendants would require a court order requiring them to refuse admission of any person into state prison who was convicted of a felony that did not meet the $950 threshold. This proposal would reduce the ADP at CDCR's adult institutions by 2,152 in December 2011.

The estimates for this proposal were obtained by a file review of 577 cases of inmates who were sent to prison based on the violations of specific state code sections. The files were then reviewed to determine the number of inmates that would not have been returned to custody if the property threshold was raised in value. This number was then projected out to all of similarly situated inmates to arrive at an anticipated reduction in ADP.

C. ALTERNATIVE CUSTODY PROGRAM

The Administration will seek legislation to establish a program of alternative custody options for lower-risk offenders. Certain offenders would be eligible to serve the last 12 months of their sentence under house arrest with GPS monitoring. House arrest may include placement in a residence, local program, hospital, or treatment center. Eligible inmates include inmates with 12 months or less remaining to serve, elderly inmates, and medically infirm inmates. The custody criteria is:

- non-violent (current and prior terms)
- non-serious (current and prior terms)
- no sex offenders
- low or moderate risk on the California Static Risk Assessment
- no immigration hold
- did not serve a Security Housing Unit term during current term of incarceration
- no guilty finding for serious rules violations listed in Title 15, section 3315, subdivision (a)(3)(A) through (a)(3)(C), during current term of incarceration
- no history of escape
- no holds, warrants, detainers
- no stay in a Psychiatric Services Unit housing during current term of incarceration

Absent additional legislation, this Court would need to waive Penal Code section 1170(a), which requires a term of imprisonment in State prison. Additionally, the Court may need to waive article I, sections 28(a)(5) and 28(f)(5) of the California Constitution.

The State estimates that this program will net an approximate 4,800 reduction in ADP by December 2011. The 4,800 ADP number is an estimate based on both eligible inmates in prison at the time (in July 2009, when the estimate was completed) and eligible new admissions projected to come into prison. The latter projection is based on a FY 08/09 intake cohort from court. This 4,800 ADP estimate also reflects a 35% discount for file review ineligibility (based on sample file reviews), a 3% discount to account for homeless parolees (based on Division of Adult Parole Operations' records for homeless parolees who would otherwise meet the criteria), and a 10% discount for those who would be unwilling to volunteer. The ADP figure is also based on an estimated length of sentence for the eligible population.

D. AB 900 CONSTRUCTION ACCELERATION

CDCR has cooperated with the *Plata* Receiver to develop CDCR's plan for healthcare beds, and has drafted legislation to enable CDCR to accelerate all of its construction authorized under AB 900 using alternative delivery methods. If the Legislature authorizes these amendments, CDCR would be able to expedite the construction of new capacity, including new healthcare facilities, and the construction of treatment and other support spaces to meet the needs of the *Plata* and *Coleman* class members.

Further, if so ordered by the Three-Judge Court, the following waivers of state laws may allow the State to complete some previously identified projects more expeditiously:

1. California Environmental Quality Act (CEQA) (Public Resources Code sections 21000-21177): The State's environmental review process is lengthy, and it invariably extends the timeframe to complete any of CDCR's construction projects. For example, with respect to the projects proposed in the State's November 6, 2009 Long-Range Mental Health Bed Plan, the CEQA process in many instances lengthens the construction timeline by more than 200 days, and in one instance (the Heman G. Stark conversion) by more than 450 days. Additionally, the environmental review process may result in litigation, which can further extend the timeframe for completing construction projects.

Waiving the CEQA process could potentially expedite construction on these projects. However, it is unknown whether the Joint Legislative Budget Committee would approve a project or if bond counsel would offer an unqualified bond opinion regarding the validity of AB 900 bonds if the Court waived the State's environmental review process. The authorization in AB 900 provides the only funding available for many of CDCR's projects. Joint Legislative Budget Committee approval is required under AB 900 and an unqualified bond opinion is necessary to market the bonds.

2. Public Contract Code (PCC) sections generally covering the approval and competitive bidding rules and requirements for State contracts:

   a. Part 1 (sections 1100 et seq.)—General Administrative Provisions.

   b. Part 2, Chapter 2, Article 2 (sections 10295 et seq.)—Approval of Contracts.

c. Part 2, Chapter 2, Article 3 (sections 10300 et seq.)—Competitive Bidding and Other Acquisition Procedures.

d. Part 2, Chapter 2, Article 4 (sections 10335 et seq.)—Contracts for Services.

e. Part 2, Chapter 3 (sections 12100 et seq.)—Acquisitions of IT Goods and Services.

f. Part 2, Chapter 3.5 (sections 12120 et seq.)—Acquisitions of Telecommunication Goods and Services.

E. HOUSE INMATES IN PRIVATE FACILITIES

An additional possible method to reduce the population to 137.5% of design capacity is to rapidly increase the number of available prison beds by expediting leasing, building, and/or operating new beds through establishment of private vendor contracts to house inmates and operate private correctional facilities in the State. Such waivers of state law would help expedite the contracting process and make available private correctional facilities ready for operation by a private vendor by August 2011.

The following is the list of waivers that would be required to achieve the most expedited establishment of newly constructed prison beds:

1. California Environmental Quality Act (CEQA) (Public Resources Code sections 21000-21177)—In order for the vendor to provide housing and operation services pursuant to the above-described contract with CDCR, the vendor would need to construct one or more correctional facilities. CEQA applies to discretionary "projects" proposed to be carried out or approved by public agencies. Arguably, the contract

between CDCR and the vendor may trigger CEQA in that the contract may be deemed an approval by CDCR of CEQA "projects" (including construction of a new facility). The CEQA compliance process is a time-consuming process and construction of new correctional facilities by the vendor would be further delayed if legal actions are brought to challenge the adequacy of CEQA compliance.

2. Public Contract Code (PCC) sections generally covering the approval and competitive bidding rules and requirements for State contracts (except for public works projects):

a. Part 1 (sections 1100 et seq.)—General Administrative Provisions.

b. Part 2, Chapter 2, Article 2 (sections 10295 et seq.)—Approval of Contracts.

c. Part 2, Chapter 2, Article 3 (sections 10300 et seq.)—Competitive Bidding and Other Acquisition Procedures.

d. Part 2, Chapter 2, Article 4 (sections 10335 et seq.)—Contracts for Services.

e. Part 2, Chapter 3 (sections 12100 et seq.)—Acquisitions of IT Goods and Services.

f. Part 2, Chapter 3.5 (sections 12120 et seq.)—Acquisitions of Telecommunication Goods and Services.

3. Article VII of the California Constitution—Civil service hiring requirements.

4. State Civil Service Act (Government Code sections 18500 et seq.)—The purpose of this Act is to

facilitate the operation of Article VII of the Constitution.

5. Government Code section 19130—Enumerated exceptions to the civil service hiring requirements. Waiver of this section would be needed to avoid any potential argument, even after waiver of the Article VII and the State Civil Service Act, that the existence of this section implies that contracting for personal services is not permissible unless the conditions under section 19130 are met.

The above list is a preliminary list of State laws that, if waived, would allow Defendants to expedite the process of contracting with vendors to operate private correctional facilities. However, given more time, other state law waivers or other federal court orders may be needed to accomplish this proposal.

If these waivers were obtained, it is estimated that CDCR could build, lease or contract for facilities for private vendors and reduce the population at the existing 33 adult institutions by 5,000 ADP by December 31, 2011.

F. JAIL TIME FOR ENUMERATED FELONIES

The Administration will seek legislation for the following enumerated offenses listed below that would allow the offenses to be charged as felonies, but would limit the maximum sentences to 366 days which could only be served in county jail. Thus, while convictions would result in imprisonment in county jail, the offenses would remain felonies within the meaning of section 17 of the Penal Code. This proposal does not apply to anyone who has a prior conviction set forth in Penal Code Section 1192.7(c) or have not suffered a strike within the meaning of Penal Code Section 667.5.

Absent legislation, the Court would have to order that CDCR not accept to State prison those enumerated crimes listed in this proposal.

The crimes for this proposal would be as follows:

- Health and Safety Code section 11350, subdivision (a). Possession of a controlled substance, including cocaine.
- Health and Safety Code section 11377, subdivision (a). Possession of a controlled substance, including methamphetamine.
- Penal Code section 476a. Check fraud.
- Penal Code section 487, subdivisions (b) and (c). Miscellaneous grand theft provisions involving agriculture, labor and real property.
- Penal Code sections 496 and 496d. Receiving stolen property.
- Penal Code section 666. Petty theft with a prior conviction of a certain offense.
- Penal Code section 667.5. Theft with a prior felony conviction of a certain offense.

The reduction in the ADP as a result of this proposal would be 11,815 by December 2011. To determine the reduction of ADP for this proposal, CDCR utilized data in OBIS. Specifically, CDCR looked at the number of admits to CDCR for these particular crimes. CDCR then estimated a reduction in ADP based on the average length of sentence for these individuals.

Three Judge Court-Ordered Response: Table 1

Fiscal Year		Current	Jun-2010	Dec-2010	Jun-2011	Dec-2011	Dec-2012	Dec-2013
Full Population Projections[1]		168,427	167,453	167,535	169,345	170,164	171,940	174,001
Institution Population Reduction Measures								
	Probation Reform							
	Community Corrections	0	0	900	1,915	1,915	1,915	1,915
	Sentencing Reform							
	Enhanced Credit Earning	0	2,814	3,021	2,807	2,921	3,142	3,419
	Executive Authority							
	Expansion of Out-Of-State Placements[2]	0	1,404	2,352	2,416	2,416	2,416	2,416
	Expanded Utilization of Private Prisons	0	0	0	400	800	800	800
	ICE Commutation	0	300	600	600	600	600	600
	Parole Reform							
	Summary Parole	0	3,323	4,556	4,556	4,556	4,556	4,556
	Alternative Parole Sanctions	0	119	900	1,000	1,000	1,000	1,000
	Parole Reentry Courts	0	0	50	435	435	435	435
	New Construction[3]							
	DJJ Renovations	0	300	300	1,800	1,800	2,700	2,700
	Reentry	0	0	0	500	500	500	1,000
	Infill (including Healthcare)	0	64	125	125	125	1,436	7,111
	Further Legislation/Court-Ordered Authority							
	Property Crime Thresholds	0	425	1,700	2,121	2,152	2,152	2,152
	Alternative Custody	0	0	1,200	3,200	4,800	4,800	4,800
	No-Prison Felonies	0	7,953	11,035	11,815	11,815	11,815	11,815
	Private In-State Prisons	0	0	0	2,000	5,000	5,000	5,000
	Expansion of Out-Of-State	0	0	0	0	1,500	2,500	3,600
Total Population Reduction		0,000	16,832	27,637	35,690	42,335	45,767	53,319
Institution Population[4]		150,979	133,072	123,423	117,290	109,462	107,806	99,720
Institution Crowding Rate		190%	169%	155%	147%	137.5%	135%	125%

---

[1] The current population is based on the actual population count on November 4, 2009. The projections to June 2010 and thereafter assume the transfer of any backlogged inmates into state custody.

[2] Assumes cooperation from *Plata*, *Coleman*, *Perez*, and *Armstrong* courts.

[3] The beds identified in this table reflect the actual capacity for which they are being built. The double celling rate of these facilities vary by project. However, whatever the double celling rate, the beds or projects are being designed with an appropriate amount of program and clinical space to accommodate that number of inmates. Additionally, increases in capacity in 2014 and 2015 are not reflected in this chart.

[4] Excludes inmates in camps, private facilities and out-of-state facilities.

APPENDIX E

FEDERAL STATUTE

18 U.S.C. § 3626: Appropriate remedies with respect to prison conditions

(a) Requirements for Relief.—

(1) Prospective relief.—(A) Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless—

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

* * * *

(3) Prisoner release order.—(A) In any civil action with respect to prison conditions, no court shall enter a prisoner release order unless—

> (i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and
>
> (ii) the defendant has had a reasonable amount of time to comply with the previous court orders.

(B) In any civil action in Federal court with respect to prison conditions, a prisoner release order shall be entered only by a three-judge court in accordance with section 2284 of title 28, if the requirements of subparagraph (E) have been met.

(C) A party seeking a prisoner release order in Federal court shall file with any request for such relief, a request for a three-judge court and materials sufficient to demonstrate that the requirements of subparagraph (A) have been met.

(D) If the requirements under subparagraph (A) have been met, a Federal judge before whom a civil action with respect to prison conditions is pending who believes that a prison release order should be considered may sua sponte request the convening of a three-judge court to determine whether a prisoner release order should be entered.

(E) The three-judge court shall enter a prisoner release order only if the court finds by clear and convincing evidence that—

(i) crowding is the primary cause of the violation of a Federal right; and

(ii) no other relief will remedy the violation of the Federal right.

* * * *

(g) Definitions.—As used in this section—

* * * *

(3) the term "prisoner" means any person subject to incarceration, detention, or admission to any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program;

(4) the term "prisoner release order" includes any order, including a temporary restraining order or preliminary injunctive relief, that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison;

* * * *

MOTION

Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

Nos. 09-1233, 09-1232

IN THE
Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

CALIFORNIA STATE REPUBLICAN LEGISLATOR INTERVENORS, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from Orders of the Three-Judge Court in the United States District Courts for the Eastern District of California and the Northern District of California

APPELLEE INTERVENOR CALIFORNIA CORRECTIONAL PEACE OFFICERS' ASSOCIATION'S MOTION TO DISMISS OR AFFIRM

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CORPORATE DISCLOSURE

CCPOA is a non-profit corporation organized under the laws of the State of California. As such, it has no parent, and there is no publicly-held company owning 10% or more of its stock.

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APPELLEE INTERVENOR CALIFORNIA CORRECTIONAL PEACE OFFICERS' ASSOCIATION'S MOTION TO DISMISS OR AFFIRM

Pursuant to Rule 18.6, Appellee Intervenor California Correctional Peace Officers' Association ("CCPOA") moves to dismiss the Jurisdictional Statements filed by Appellants and Appellant-Intervenors or, in the alternative, to affirm the judgment sought to be reviewed, on the ground that the questions on which they depend are so insubstantial as not to warrant further review.

JURISDICTION

This Court does not have jurisdiction to review the convening of the three-judge district court pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626(a)(3)(B), because that order is appealable only to the Ninth Circuit Court of Appeals. *See Dove v. Bumpers*, 497 F.2d 895, 896 (8th Cir. 1974) (court of appeals has jurisdiction to determine whether three-judge court properly convened); *Mayhue's Super Liquor Store, Inc. v. Meiklejohn*, 426 F.2d 142, 144-45 (5th Cir. 1970) (same).

This Court has jurisdiction under 28 U.S.C. § 1253 to review the three-judge district court's "Order to Reduce Prison Population" (State App. II:1a-10a) and its "Opinion and Order" making the requisite predicate findings (State App. I:1a-256a) (collectively, the "Orders").[1]

---

[1] "State App. I" refers to the appendix Appellants filed in Case Number 09-416. "State App. II" refers to the appendix they filed in this case.

STATEMENT OF THE CASE

Appellee Intervenor CCPOA represents the men and women who work in California state prisons: approximately 35,000 correctional officers, counselors, parole agents, medical technical assistants, and correctional sergeants and lieutenants. As peace officers, CCPOA members share the concern for public safety that compelled Congress to pass the PLRA. CCPOA intervened in this case because the extreme overcrowding in California prisons has not only caused Eighth Amendment violations, but has also endangered prison staff, making it difficult for staff to fulfill their duties.

Correctional staff are the only Intervenors who daily confront these sobering realities. In granting CCPOA's motion to intervene, the district court found: "It is plain that California's prison guards are affected by the conditions of the prisons in which they work," and that CCPOA was "uniquely situated" to provide evidence regarding prison conditions. *Coleman* Docket No. 2427.

Appellants and their Intervenors overstate the conflict between the State and the district court. Although Appellants *argued* in the three-judge proceeding that the constitutional violations had been remedied, the State has conceded as recently as September 2009 that the constitutional violations continue. *See Plata* Appellees' Motion to Dismiss or Affirm, at pp. 14-15. The State has also not sought to lift the special master appointment or the receivership, respectively, on the basis that the State had remedied the constitutional violations. State App. I:77a. In fact, the State never even appealed the finding of constitutional violations in *Coleman* and stipulated to liability in *Plata*. *See* State App. I:15-16a, 31-32a.

CCPOA supported Appellees' efforts to convene the three-judge court because the single-judge district courts had exhausted all other means to bring the California prison system into compliance with the Eighth Amendment. As described below, correctional officers did their best to fulfill their duties under these extremely difficult, unconstitutional conditions.

The three-judge court found that correctional staff were "essential to providing healthcare to prisoners." State App. I:110a, quotation and citation omitted. Among other roles, correctional officers escort prisoners to medical services within an institution, and they supervise and protect prisoners transported elsewhere for treatment. *See ibid.* Perhaps more importantly, correctional staff are primarily responsible for alerting medical staff when prisoners complain of acute medical issues, and are charged with observing prisoners to identify medical or mental health issues. *See ibid.*

But as correctional officers testified at trial, the over-crowding in California prisons makes it difficult for them to perform these vital functions, which in turn directly affects inmate medical and mental health care:

- Officer Brenda Gibbons testified that she was required to place suicidal prisoners in converted supply closets due to the shortage of available suicide watch beds, where she observed them for hours at a time. Trial Tr. 558-560, 575-576. Even though the prison regulations set time limits for holding suicidal prisoners in such settings, officers had been ordered to cycle suicidal prisoners from these cells to another room and back again because of the shortages, resulting in overnight stays. *Id.* at 575.

- Due to the lack of adequate treatment space, half of the mental health treatment services that Officer Gibbons observed occurred in the prison yard, which meant that programs were frequently cancelled due to inclement weather or during emergencies elsewhere in the prison. *Id.* at 566, 577.

- Inmates wait hours for medical care in chaotic and unsafe conditions. Officer Gary Benson testified that up to fifty inmates routinely wait in a "holding caged area" for two to five hours, to see a doctor in a 20-foot by 35-foot "clinic." Doctors examine four to six inmates in the same tiny room, surrounded by unlocked boxes of needles, scissors and narcotics. Officer Benson is the only officer present. Trial Tr. 592-599.

- Debbra Rowlett is a correctional officer and a licensed nurse. Trial Tr. 657, 659-660. She testified that she witnessed inmates standing in lines 300 people deep to obtain their prescribed psychotropic medications. Officer Rowlett testified that inmates sometimes receive the wrong medication. Correctional staff and nurses have no time to double-check prescriptions, ask about adverse effects, or ensure that inmates consume their medication—all essential for proper medical care. Unsupervised prisoners may have their medication stolen by other inmates, or hoard it, rather than consuming it. Officer Rowlett testified that at least one prisoner died after purposely overdosing on hoarded medication. *Id.* at 665-667.

- Correctional Sergeant Kevin Raymond works on a team responsible for prison construction and operations planning. Trial Tr. 535-536. He testified that the majority of California prisons were designed with sufficient medical space to treat a population based on only one inmate per cell, yet CDCR planned to house two inmates per cell. *Id.* at 542-543. Thus almost all California prisons have less than half the space necessary to provide adequate medical care at current population levels. But even if there were sufficient space, correctional officers testified that there are insufficient correctional officers to transport inmates to appointments or to monitor them. Trial Tr. 679, 692; *see also* State App. I:110a.

These officers' testimony made plain how overcrowding strained every resource beyond the breaking point, and the impact that had on correctional staff and inmates.

Their testimony also demonstrated that sufficient correctional-staff-to-inmate ratios are essential for delivery of constitutionally-adequate medical and mental health services to California prisoners. The three-judge district court, however, found that "[t]he California prison system lacks sufficient custodial staff . . . to provide prisoners with timely access to [medical] care and still perform other essential [penological] functions." State App. I:110a, quotation and citations omitted. The evidence established that understaffing undermines health care services, placing prisoners at substantially increased risk of further deterioration. State App. I:111-112a. Despite their best efforts, overworked correctional staff are less-well placed to respond to medical emergencies because of "forced overtime and burnout" (State App. I:111a, internal quotations and citations omitted) and because it is unsafe to leave hundreds of prisoners supervised by only one officer so that his or her partner can take a sick inmate to receive medical care. *Id.* at 110-111a.

Based on this and other evidence presented during a multi-week trial the three-judge district court concluded that overcrowding was the primary cause of the constitutional violations in California prisons. State App. I:140-143a. After determining that no other relief would remedy the constitutional violations (*id.* at 168a), that it was the least intrusive remedy (*id.* at 168-175a), and that public safety would not be adversely affected (*id.* at 220-234a), the three-judge court ordered the State to propose a plan to reduce the prisoner population to 137.5% of design capacity within two years. *Id.* at 255-256a. It did not order any specific mode of relief much less any prisoner release but instead allowed the State to design its own plan in the first instance. *Id.* The court outlined numerous options available to the State to comply with its order (*id.* at 192-220a), many of which the Governor himself recently proposed to the Legislature for independent budgetary reasons, including a prisoner reduction of 37,000 over two years. *See Plata* Docket No. 2269.

The State's first submitted plan did not comply with the most basic parameters of the court's order. *Plata* Docket No. 2269; *see also* State App. II:3a. Accordingly, the court rejected the State's plan on October 21, 2009, and gave the State even more time to submit a plan that did comply. *Ibid.* On November 12, the State filed its second proposed population plan, which complied with the three-judge court's orders. *See* State App. II:3a.

The three-judge court approved the State's revised plan on January 12, 2010 and ordered the State to implement the six-month population reduction benchmarks. *Ibid.* The court did not "endors[e] or order[] the implementation of any of the specific measures" in the revised plan. Rather it gave the State "maximum flexibility" to determine which "specific population reduction measures" it would use. State App. II:3-4a. The three-judge court thus ordered the State to reduce the prison population—through the means it deemed best—to 167% of design capacity in six months, 155% in 12 months, 147% in 18 months, and 137.5% in twenty-four months. State App. II:6-8a. The three-judge court stayed its order until resolution of any appeal to this Court, noting that the stay gave California "additional time" to voluntarily comply with its orders through the political process. *Id.* at 8-9a.

Three days later, on January 15, 2010, this Court dismissed the State's premature appeal from the August 4, 2009 order. *Schwarzenegger v. Plata*, 130 S. Ct. 1140 (2010). The State filed this second appeal on January 19, 2010.

THE CHALLENGED ORDERS ALLOW CALIFORNIA TO CRAFT A POPULATION CAP IN ACCORD WITH ITS PRIORITIES

CCPOA supports affirming the three-judge district court's actions below or, in the alternative, dismissing Appellants' and Intervenors' Jurisdictional Statements.

Despite its inapt name and Appellants' repeated implication, a "prisoner release order"[2] under the PLRA does not require California to fling open its prison gates. CCPOA cedes ground to no one in its concern for public safety and would not support so indiscriminate an order. Rather, a "prisoner release order" is "any order . . . that has the purpose or effect of reducing or limiting the prison population . . . ." *See* 18 U.S.C. § 3626(g)(4).

Appellants make no case that lawlessness is imminent. The overwhelming testimony at trial supported the three-judge court's conclusion that a prisoner population reduction "would not adversely affect public safety" if the State implemented appropriate measures. State App. I:249a; State App. II:4a. Nothing prevents the State from implementing systemic reforms to safely reach constitutional conditions. The State is not limited to its history of inaction or contradictory actions, such as issuing a plan dependent upon rehabilitation services while slashing the CDCR budget for rehabilitative programs. *See Plata* Docket 2269.

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[2] The version of the PLRA in effect before the 1996 amendments more accurately described such an order as an "inmate population ceiling." *See* Pub. L. No. 103-322, § 20409, 108 Stat. 1827 (1994) (formerly codified at 18 U.S.C. § 3626(b) (1995)).

Moreover, the Governor himself proposed reducing the prison population by 37,000 in two years for budgetary reasons, and the State conceded that the Governor would not make proposals that are not safe. *See Plata* Docket 2258; *see also* Trial Tr. 2984:7-2985:15. Understood in this context, Appellants essentially take the position that they cannot safely reduce the prison population when required to do so by the Constitution, but that they can do so for budgetary reasons. As explained above, the truth is that the State executive and legislative branches have before them a broad range of methods by which to implement a population cap that "ensur[es] the public safety." State App. II: 4a.

Appellants insist that the three-judge court only examined "the state of staffing in 2007" when it determined that increased staffing alone would not cure the constitutional deficiencies. State J.S. 22-23. Appellants also claim that CDCR hired such a large number of "custodial staffers . . . dedicated [to] 'access to care' units" in 2007 and 2008 that "[prisons] are actually overfilled." State J.S. 16. The first contention is incorrect, and the second is misleading because it ignores understaffing in other parts of each prison.

The court considered officer testimony during the late 2008 trial that in prison dormitories, one or two correctional officers supervise approximately 200 inmates. State App. I:111a. It found that when a prisoner medical emergency arises under these conditions custodial staff "can only sound the alarm, make frantic telephone or radio calls, and hope for backup." *Ibid.* For example, Officer Rowlett testified that if officers respond to a serious medical emergency (as she and her partner had to with an inmate who suffered three seizures a day), no correctional officer is available to supervise the other almost two hundred inmates, creating a safety hazard for inmates and staff. Trial Tr. 678-680. CCPOA also produced other evidence at trial showing that many units in state prisons were currently understaffed. *See, e.g.*, Trial Tr. 571 (testimony from late 2008 by Officer Gibbons that staff were required to work 16-hour shifts due to understaffing); *id.* at 660 (Officer Rowlett testifying that overcrowding impacts "amount of care" staff is able to give inmates at current staffing levels); *id.* at 678 (at current staffing levels, correctional officers unable to monitor inmate medical conditions in dormitories holding 250-300 prisoners).

The three-judge court also relied on evidence from the *Plata* Receiver that in 2008 custodial understaffing and the State's lack of an "organizational structure and processes" for escorting prisoners to medical appointments resulted in "denial of timely access to health care services and substantially increases the risk that [prisoners'] health will further deteriorate." State App. I:111-112a, citations and quotations omitted. As late as September 2008, Appellees' expert Dr. Shansky opined that inadequate correctional staffing "caused significant delays in treatment." State App. I:112a, citation and quotation omitted.

Thus, the court explicitly considered whether additional staffing alone would resolve the constitutional deficiencies and found that it would not. The court concluded, after considering the extensive evidence before it, that "[a] reduction in the crowding of California's prisons would help ease the burden on the custodial staff and permit staff members to better monitor inmates for medical or mental health problems and to deliver inmates for necessary care." State App. I:112a. Overcrowding strains correctional staffs' ability to provide services to prisoners, including access to medical and mental healthcare. The facts before the three-judge court demonstrated that prisons are far from being adequately staffed to facilitate delivery of constitutionally-adequate medical and mental healthcare.

CONCLUSION

For all these reasons, this Court should dismiss the appeals and/or affirm the three-judge district court's orders.

Respectfully submitted,

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MOTION

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Nos. 09-1232 & 09-1233

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Appellees.

On Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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QUESTIONS PRESENTED

1. Whether the Court's jurisdiction under 28 U.S.C. § 1253, which extends to orders "granting or denying ... an interlocutory or permanent injunction" rendered "by a district court of three judges," authorizes direct review of a single-judge district court's decision to convene a three-judge panel.

2. Whether the three-judge court clearly erred in concluding that the conditions for a prison population cap under 18 U.S.C. § 3626(a)(3)(E) were satisfied based on its fact-intensive determinations (i) that prison overcrowding is the primary cause of California's failure to provide inmates with constitutionally adequate mental and medical healthcare, and (ii) that, in light of numerous unsuccessful previous court orders spanning years of failed remedial efforts, "no other relief" would remedy the ongoing constitutional violations.

3. Whether the three-judge court's order requiring California to bring its prison population to within 137.5% of its prisons' total design capacity, while affording state officials broad discretion to choose which remedial measures will safely and effectively address the prison overcrowding crisis, is narrowly drawn, extends no further than necessary, and is the least intrusive means necessary to correct the ongoing violations of inmates' federal constitutional rights.

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MOTION TO DISMISS OR AFFIRM

Pursuant to Sup. Ct. R. 18.6, the *Coleman* appellees move to dismiss this appeal in part because the Court lacks jurisdiction to review a district court's decision to convene a three-judge court. The remaining questions presented are so fact-bound that this Court's plenary review is unwarranted. For reasons set forth below and for additional reasons set forth in the motion to dismiss or affirm filed by the *Plata* appellees, the Court should summarily affirm the lower court's decision.

JURISDICTION

The Court has jurisdiction under 28 U.S.C. § 1253 over appeals from orders of the three-judge court granting or denying injunctive relief, but it lacks jurisdiction over appeals from the single-judge courts' orders granting plaintiffs' motions to convene the three-judge court. Where jurisdiction lies, prudential considerations counsel against granting plenary review and in favor of summary affirmance.

STATEMENT OF THE CASE

This case seeks the Court's plenary review of an order issued by a three-judge district court, convened under the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626, requiring California to take whatever steps it deems necessary to ensure that, within two years, its prison population does not exceed 137.5% of its prison facilities' total design capacity. After a two-month trial, at which dozens of witnesses testified about current prison conditions, the three-judge court held that capping the prison population is the least intrusive remedy that will ease the unprecedented and entrenched overcrowding crisis and allow the State to resolve the long-standing and continuing constitutional violations found by the single-judge district courts in *Coleman v. Schwarzenegger* and in *Plata v. Schwarzenegger*. Those courts determined that every day prisoners' lives and health are threatened because California is not providing constitutionally adequate mental health care (*Coleman*) or constitutionally adequate medical care (*Plata*) to inmates with serious needs. Despite more than 70 previous court orders, dozens of special master reports, numerous iterations of remedial plans spanning two decades of litigation, and even a receivership, severe overcrowding has prevented the State from resolving its inhumane prison conditions.

A. California's Prison Crisis

California's prison system is in the midst of what its Governor has called a severe "overcrowding crisis." Int.App. 61a. This crisis has prevented the State from remedying egregious problems infecting its prison medical and mental health care systems, which "'too often sink[] below gross negligence to outright cruelty,'" *Plata v. Schwarzenegger*, No. 09-15864, 2010 WL 1729472, at *2 (9th Cir. Apr. 30, 2010) (quoting *Plata* D.E. 371), and condemn prisoners to "horrific conditions without access to immediate necessary mental health care." *Coleman* D.E. 1800 at 2. If the system is not "'dramatically overhauled,'" an "'unconscionable degree of suffering and death is sure to continue.'" *Plata*, 2010 WL 1729472, at *2 (quoting *Plata* D.E. 371).

These intolerable conditions are especially acute with respect to mentally ill prisoners. California prisons lack adequate treatment resources and, as a result, "critically mentally ill inmates" are left to "languish[] in horrific conditions without access to immediately necessary mental health care." Int.App. 45a. The prisons cannot transfer mentally ill patients to appropriate levels of care in a timely fashion. Int.App. 46a–47a. Systemic understaffing creates additional risks of serious harm. Int.App. 108a–112a. And suicides are occurring at an alarming rate. In 2006, California's suicide rate of 25.1 suicides per 100,000 inmates was nearly double the national average. Int.App. 123a.

The State has recognized the dangers of overcrowding. In 2004, the State's Corrections Independent Review Panel warned that overcrowding imperiled the safety of inmates and employees. Int.App. 56a. A year later, officials warned of "an imminent and substantial threat" to public safety from overcrowding. *Coleman* D.E. 2038 at ¶ 12. By 2006, California's prison population reached record levels, and since then its adult prison facilities have operated at nearly double their intended capacity. Int.App. 9a. In October 2006, the Governor declared a "Prison Overcrowding State of Emergency," acknowledging that all 33 of California's prisons "are now at or above maximum operational capacity, and 29 of the prisons are so overcrowded" that more than 15,000 prisoners are being held in conditions that pose "substantial safety risks." Int.App. 61a. The Governor noted that, in addition to the basic "lack of appropriate beds and space," the suicide rate is "approaching an average of one per week." *Id.*; Pls.' Trial Ex. 1 at 6. As the Governor explained, "the overcrowding crisis gets worse with each passing day, creating an emergency in the California prison system." *Id.*

Notwithstanding the Governor's emergency declaration, the State has been unable or unwilling to remedy overcrowding and, as a result, has failed to fix the constitutional deficiencies in its prison medical and mental health care systems. Although there have been modest improvements in some areas, the Governor's declared emergency remains in effect and conditions continue to deteriorate. The wait list for psychiatric inpatient care has reached unprecedented levels. *Coleman* D.E. 3831 at 2–3; Pls.' Trial Ex. 244 at 900129 (in February 2010, 574 male inmates wait-listed for high custody inpatient care, a three-fold increase since August 2008). As of March 2009, the State had no "viable" plan to increase mental health beds and treatment space, *Coleman* D.E. 3540, and its now-existing plan will not be implemented for nearly four years under the most optimistic scenario. *See Coleman* D.E. 3761. Unacceptable staff vacancy rates remain. *See Coleman* D.E. 3638 at 375–378. Inmates with serious mental disorders continue to "languish" in reception centers and in administrative segregation. *Id.* at 399. Transfers to mental health crisis beds "almost never" occur within clinically necessary timeframes and "delays of two weeks" are "common." *Id.* at 403. A recent Special Master report shows that 82 percent of suicide cases were preventable and/or foreseeable due to "inadequacy in assessment, treatment, or intervention"—the "highest rate of inadequacy in these areas in the past several years." *Coleman* D.E. 3677 at 1.

B. The Single-Judge Court Proceedings

California's unconstitutional prison conditions are not a recent phenomenon. The *Coleman* litigation began more than 20 years ago, in 1990, when plaintiffs filed suit on behalf of prisoners suffering from serious mental illness. Bringing claims under the Constitution's Eighth and Fourteenth Amendments, the *Coleman* plaintiffs challenged the adequacy of mental health care at institutions within California's Department of Corrections. (Nine years ago, the *Plata* plaintiffs filed a similar suit on behalf of prisoners with serious medical needs failing to receive constitutionally adequate medical care.)

In 1995, the *Coleman* district court held that the State's delivery of mental health care to prisoners suffering from mental illness violated the Eighth Amendment. The court found "significant delays in, and sometimes complete denial of, access to necessary medical attention, multiple problems with use and management of medication, and inappropriate use of involuntary medications." *Coleman v. Wilson*, 912 F. Supp. 1282, 1308–09 (E.D. Cal. 1995). It noted that the prisons, by the State's own admission, were "chronically understaffed." *Id.* at 1306. And it found that the State lacked an adequate mechanism for screening mentally ill patients. *Id.* at 1312.

In the wake of that 1995 ruling, the State, along with a court-appointed Special Master, developed the first of a long series of attempted remedial plans, and the court directed the Special Master to monitor the State's attempts to implement its plan. Int.App. 36a–37a. In the past 12 years, the Special Master has filed 21 monitoring reports and 57 other reports. Int.App. 38a; *Coleman* D.E. 3638, 3677. In addition, the court has issued "well over seventy orders concerning matters at the core of the remedial process." Int.App. 38a–39a.

None of these efforts has proven successful. As the single-judge court concluded, at no point since the *Coleman* plaintiffs filed their action two decades ago has California brought its mental health care delivery system into compliance with basic constitutional requirements. Int.App. 67a. Constitutional violations have persisted and indeed worsened. Int.App. 123a, 132a.

C. The Decision To Convene A Three-Judge Court

In November 2006, following the Governor's emergency announcement, the *Coleman* plaintiffs filed a motion to convene a three-judge court under 18 U.S.C. § 3626. That provision—entitled "Appropriate remedies with respect to prison conditions"—sets out the procedures by which a three-judge court may be convened to consider the appropriateness of a "prisoner release order." Under the PLRA, a "prisoner release order" is broadly defined to include not only orders that call for the release of prisoners but also any order "that has the purpose or effect of reducing or limiting the prison population." *Id.* § 3626(g)(4).

The single-judge court conducted an initial hearing in December 2006. At that hearing, the court granted a six-month continuance, offering the State an opportunity to demonstrate progress and outline measures it would take to improve prison conditions. Int.App. 68a–69a. The single-judge court also sought input from the Special Master, who concluded that ongoing space, bed, and staffing shortages were "unquestionably exacerbated by overcrowding." Int.App. 69a. The Special Master estimated that the State "cannot meet at least ... 33 percent[] of acknowledged mental health needs.". Int.App. 68a–69a. It concluded that many of the State's achievements over the preceding 11 years had "succumbed to the inexorably rising tide of population." Defs.' Trial Ex. 1292 at 17.

The single-judge court reconvened proceedings in July 2007. Unfortunately, during the six-month continuance, conditions in California's prisons had further deteriorated. *See Coleman* D.E. 2156, 2236, 2301. Determining that the PLRA's requirements were satisfied, the court granted plaintiffs' motion to convene a three-judge court. Int.App. 65a. The court found that prison conditions had not improved and that the 33% rate of "unmet needs" in a mental health caseload of nearly 33,000 inmates was unconscionable. Int.App. 67a–69a. While acknowledging some progress, the court observed that California's "mental health care delivery system has not come into compliance with the Eighth Amendment *at any point since this action began*." Int.App. 67a (emphasis added). (At the same time, as described in the *Plata* appellees' motion, the *Plata* court entered a separate order granting the *Plata* plaintiffs' motion to convene a three-judge court.)

D. The Three-Judge Court Proceedings

The then-Chief Judge of the Ninth Circuit convened the three-judge court on July 26, 2007, ordering (without objection) that the same three-judge court would address the appropriate remedy in both *Coleman* and *Plata*. Int.App. 69a.

1. Current Prison Conditions

From September through December 2007, the parties engaged in extensive discovery. Discovery included prison tours in which the State's experts observed treatment areas, reviewed files, and interviewed prisoners and clinicians. *See* Defs.' Trial Exs. 1016, 1019. Plaintiffs' experts also conducted tours and prepared extensive reports describing the ongoing deficiencies in the prisons' medical and mental health care systems. *See Coleman*, D.E. 3201, 3217, 3231–10, 3231–14.

In November 2007, the three-judge court, affording the State another opportunity to avoid judicial intervention, referred the matter to a settlement referee. Int.App. 69a–70a; *Coleman* D.E. 2620, 2808. Settlement efforts were unsuccessful. From July through September 2008, the parties and their experts conducted new prison inspections and prepared new reports. *See* Defs.' Trial Exs. 1017, 1020; *Coleman* D.E. 3201, 3221, 3231–9, 3231–13, 3231–15. The parties acquired extensive information about the current state of California's prisons, analyzing electronically stored information from over 80 state officials and deposing 16 officials with responsibility for overseeing California's prisons.

At the close of discovery, the State filed a motion for summary judgment. Plaintiffs responded with overwhelming evidence of continuing constitutional violations. *Coleman* D.E. Nos. 3054–3061, 3063–3064. The three-judge court denied the State's motion in its entirety and set the matter for trial. Int.App. 70a.

At a pre-trial conference, the three-judge court clarified the scope of its proceedings, emphasizing that its role was not to re-adjudicate the existence of the underlying constitutional violations found by the single-judge courts. The three-judge court made clear that if the State wanted to make the case that violations no longer existed, it should direct that argument to the single-judge courts. 2008-11-10 Pre-Tr. 28–29. The three-judge court made equally clear, however, that the State had broad leeway to present evidence relevant to the PLRA's requirements, including the necessity of the remedy to address current conditions. *See, e.g.*, Tr. 837 (evidence of current conditions allowed to "illuminate[] the questions ... properly before the court"). Under the PLRA, an order limiting prison population is appropriate only if a three-judge court finds, by clear and convincing evidence, that (1) crowding is the "primary cause" of a violation of federal rights, and (2) "no other relief" will remedy that violation. 18 U.S.C. § 3626(a)(3)(E).

2. The Trial

Trial occurred in November and December 2008. Over that period, the court reviewed thousands of exhibits and considered oral and written testimony from nearly 50 expert and percipient witnesses. The evidence confirmed that California's overcrowded prison conditions have prevented the State from remedying its constitutionally inadequate medical and mental health care services.

The State's own witnesses testified at length as to problems associated with prison overcrowding and the current state of medical and mental health care. *See* Tr. 781–783 (shortages of inpatient placements), 770–775 (recent suicides in acute mental health unit), 796–799 ("overbedding" patients and turning patients away), 808 (waiting lists), 812–813 (efforts to recruit and hire mental health staff), 841–842 (unavailability of treatment space), 853–856 ("terribly overcrowded" conditions affecting mental health care), 904–906 (staffing levels). The State's mental health expert, Dr. Ira K. Packer, Ph.D., testified that the "primary cause" of California's inadequate mental health care system is that prisons have "many more acutely mentally ill individuals and at a level of more severity than had been anticipated when the prisons were built." Tr. 1079. In his "professional opinion, the lack of adequate intensive mental health treatment beds … is the *primary cause* of the deficiencies in providing mental health care to mentally ill inmates." Defs.' Trial Ex. 1019 at 8 (emphasis added). Dr. Packer also testified that, in his "opinion, crowding is the *primary cause* of the particular difficulties in providing services" to mentally ill prisoners at "reception centers." *Id.* at 20 (emphasis added).

Intervenors' witnesses also conceded the harmful effects of overcrowding. For example, assembly-member Todd Spitzer, an outgoing chair of a select assembly committee on prisons, admitted that there is a "terrible overcrowding problem in California"; that California's prisons are "relatively inhumane"; and that recent legislation intended to address overcrowding by building new prisons had not been successfully implemented. Tr. 2460, 2461; *see also* Tr. 2733 (testimony of Sen. George Runner).

Other witnesses, including five correctional officers, testified that overcrowding directly affected the State's continued failure to provide adequate medical and mental health care. *See* Tr. 509–510, 519 (too many prisoners with medical needs for space and staff), 575–577 (dangerously inadequate housing for suicidal prisoners), 601 ("way too many inmates" for treatment space), 664 (treatment room simultaneously shared by scheduling secretary and practitioners conducting hemorrhoid exams), 663–664 (patient intakes occur in hallways), 661–662, 665–666, 671 (insufficient staff monitoring provision of insulin and narcotics), 662–663, 668 (staff overwhelmed), 691, 693 (prison too crowded to monitor medical conditions).

On February 9, 2009, the three–judge court issued a tentative ruling, finding that plaintiffs had "presented overwhelming evidence that crowding is the primary cause of the underlying constitutional violations." *Coleman* D.E. 3514 at 2. The court noted that the overcrowded prison system "is itself, as the Governor as well as experts" have recognized, "a public safety hazard." *Id.* at 9. As the court explained, the uncontroverted evidence showed that, because of overcrowding, the State lacks sufficient clinical facilities, resources, and personnel to provide minimally adequate medical and mental health treatment. *Id.* at 3. The court also noted that the State's Independent Review Panel, chaired by former (Republican) Governor George Deukmejian, found that a prison population of 145% of design capacity was the outer limit for California prisons. *Id.* at 6. But, as the court explained, that outer limit did not account for the resources needed to provide even minimally adequate medical and mental health care. *Id.* The State's witnesses testified that new facilities should be limited to a population of no more than 130% of design capacity, while other experts testified that specialized mental health clinical programs should operate at or below 100% of design capacity. *Id.*

The court nonetheless offered the State another opportunity to avoid further judicial intervention by granting time to resume settlement discussions. Int.App. 70a. The court waited for six months, but the State declined to negotiate a settlement.

3. The Orders Below

On August 4, 2009, the three-judge court issued a 183-page opinion and order finding that a 137.5% population cap was necessary to remedy the ongoing constitutional violations and that plaintiffs had satisfied each of the PLRA's requirements. Int.App. 1a–256a. Noting that "we do not intervene in matters of prison population lightly," the court underscored that 14 years of remedial efforts in *Coleman* had passed without resolving the underlying constitutional violations. Int.App. 12a, 31a.

1. The three-judge court found that overcrowding was the "primary cause" of the State's ongoing failure to provide constitutionally adequate mental health care services. Int.App. 82a. Although the court acknowledged that overcrowding was not the only cause of the constitutional violations, it found that until the State resolved the overcrowding crisis it would "be impossible to provide constitutionally compliant care to California's prison population." Int.App. 142a.

That finding was supported by clear and convincing evidence. The evidence showed that overcrowding has exacerbated space, bed, and staff shortages, which continue to impede thorough health screenings and adequate emergency responses to those in need. Int.App. 91a–92a (inadequate care in reception centers); Int.App. 98a; 92a–95a (current space shortage); 101a–102a (current crowded conditions increasing spread of diseases); 103a (current crowded conditions "toxic[]" to mentally ill); 105a–112a (current staff shortages); 116a–118a (current lockdown problems preventing access to care); 121a–123a (current crowding increasing acuity of mental illness). Overcrowding has escalated "the incidence of mental illness" and exacerbated "the condition of those already mentally fragile and vulnerable." Defs.' Trial Ex. 1292 at 8. In addition, because mentally ill prisoners "often spend months in a reception center with little or no access to necessary mental health care while waiting for a bed," overcrowding has prevented adequate prisoner screening and treatment. Int.App. 85a–92a. Overcrowding has also overwhelmed the prisons' medication management system. Int.App. 112a–114a.

The court found that "no other relief" short of a population cap would bring the prison system into compliance with minimum constitutional requirements. Int.App. 168a. That finding was also supported by clear and convincing evidence, including testimony from current and former heads of multiple state prison systems. Int.App. 162a–164a. As the court explained, "[o]ther forms of relief are either unrealistic or depend on a reduction in prison overcrowding for their success." Int.App. 168a. Additional hiring is unrealistic because current facilities lack space for new hires and clinical vacancy rates are consistently high. Int.App. 108a–109a, 154a–155a. Relying solely on a Special Master is not a viable solution, as years of litigation have already proven. Int.App. 156a–157a. The court gave full consideration to prison construction plans, but found that the State had no "actual, feasible, sufficiently timely" prospect of completing them. Int.App. 146a. The State's proposal to transfer 3,000 prisoners out-of-state would entail too small a population reduction to remedy the constitutional violations. Int.App. 160a–161a, 327a.

The three-judge court likewise concluded that a 137.5% population cap is a narrowly tailored remedy. Int.App. 169a, 175a–185a. Significantly, the court did not mandate individual population-reduction measures; instead, it urged the State to develop its own remedial plan. The court emphasized that the State "would not be required to throw open the doors of its prisons, but could instead choose among many different options or combinations of options." Int.App. 173a–174a.

2. The State sought a stay from this Court, which was denied. *Schwarzenegger v. Coleman*, 130 S. Ct. 46 (2009). The State then submitted a remedial plan that, because it proposed only half-measures, was rejected by the three-judge court as non-compliant. *Coleman* D.E. 3711. Finally, in November 2009, the State submitted a revised plan to bring the prison population to 137.5% of design capacity within two years. The plan incorporates many elements—including good-time credit earning enhancements, re-entry courts, and parole reforms for low-risk offenders—that are required under

recently-enacted state prison reform legislation (Senate Bill 18) and that the State's own experts and officials have previously endorsed as *improvements* to public safety. Int.App. 196a-216a, 321a-329a, 344a-348a.

At the same time it developed a remedial plan, the State sought this Court's review. *Schwarzenegger v. Plata*, 130 S. Ct. 1140 (2010); *California State Republican Legislators v. Plata*, 130 S. Ct. 1142 (2010). The Court denied that request on January 19, 2010 and dismissed for lack of jurisdiction.

3. On January 12, 2010, the three-judge court entered a final order accepting the State's proposed plan. Int.App. 257a-266a. Reiterating that it did not "intervene lightly in the State's management of its prisons," Int.App. 265a, the court held that it would not mandate any specific measures in the State's plan—affording the State maximum discretion to decide which options would best achieve constitutional compliance. The court emphasized its "hope that California's leadership will act constructively and cooperatively ... so as to ultimately eliminate the need for further federal intervention." *Id.*

ARGUMENT

All the State's arguments challenging the three-judge court's order are grounded in the same fact-bound objection—namely, that the remedy imposed is unnecessary and premature. But even a cursory appreciation for the chronology of this extraordinary case exposes the weakness of the State's position. In the circumstances of this case, *requiring* California to address its prison overcrowding crisis is a justified and appropriate remedy under the PLRA.

The three-judge court's order requiring California to implement its plan to reach a prison population of 137.5% of total design capacity within two years—an admittedly unusual, but expressly contemplated, remedy under the PLRA—came nearly *fifteen years* after a single-judge court determined that "seriously mentally ill inmates in the California Department of Corrections daily face an objectively intolerable risk of harm as a result of the gross systemic deficiencies that obtain throughout the Department." *Coleman*, 912 F. Supp. at 1316. The order followed a lengthy post-judgment remedial period, spanning three California governorships, during which the State's prison administrators worked closely with a Special Master in a failed attempt to remedy the deficiencies. The order came after more than 70 court orders and 20 Special Master monitoring reports proved ineffective in the face of a prison population spiraling out of control. And the order came after California's Governor admitted that California's prisons face a serious "health care crisis" and "overcrowding crisis" because "for decades the state of California hasn't really taken it seriously." Pls.' Trial Ex. 384.

Urging the Court to overlook this case's history, the State devotes much of its jurisdictional statement to unfortunate hyperbole, exaggerating the burdens of the lower court's order while downplaying the unprecedented seriousness of California's prison crisis. It is therefore important to emphasize what is not at issue in this appeal: "defendants' mental health care delivery system has not come into compliance with the Eighth Amendment at any point since this action began" in 1990. Int.App. 67a. The following facts are also not in reasonable dispute: The single-judge court in *Coleman* found that California's prison system poses an "objectively intolerable risk of harm" to seriously mentally ill inmates. Int.App. 170a. The single-judge court in *Plata* found that "future injury and death" of California prisoners is "virtually guaranteed in the absence of drastic action." *Id.* And, in both cases, the State has failed to remedy those deficiencies despite having "every reasonable opportunity" to do so. Int.App. 74a, 170a.

The State's jurisdictional statement suggests that progress has been made and hints that the constitutional violations may no longer exist. But these suggestions are directly contrary to the record evidence and the facts found by both the single-judge and three-judge courts, and the State maintains the option of demonstrating the absence of constitutional violations to the single-judge court. Indeed, the State does not (and cannot) dispute that some judicial remedy for ongoing constitutional violations is urgently needed, even as it challenges the particular remedy selected by the three-judge court.

The State's arguments instead boil down to a dispute over whether the remedy ordered is warranted under the State's view of *the facts*. But the ongoing exigencies, uncommonly expansive record, and fact-intensive nature of the questions raised render this case a poor candidate for this Court's plenary review. Just as fact-bound assessments are poor candidates for this Court's certiorari jurisdiction, *see* Sup. Ct. R. 10, the questions raised here do not merit this Court's plenary review.

I. The Three-Judge Court Was Properly Convened Under The PLRA But The Issue Is Not Properly Before This Court.

The State argues that the three-judge court lacked jurisdiction because it was purportedly convened before the State had "a reasonable amount of time to comply with the previous court orders." SJS 11–18. This argument is not properly before the Court. It also lacks merit.

1. This Court has jurisdiction to review orders "*granting or denying ... an interlocutory or permanent injunction* in any civil action, suit or proceeding required by any Act of Congress to be heard and determined *by a district court of three judges*." 28 U.S.C. § 1253 (emphases added). The decision to convene a three-judge court, however, is neither an "order granting or denying ... an interlocutory or permanent injunction," nor a decision "by a district court of three judges." *Id.*; *Gonzalez v. Automatic Employees Credit Union*, 419 U.S. 90, 97 n.14 (1974) (§ 1253 restricts "jurisdiction to orders actually entered by three-judge courts"). Instead, it is a decision made by the district court judge (actually two separate district court judges in separate orders, neither of which is appealable directly to this Court), who is responsible for determining whether constitutional violations exist and has authority to convene a three-judge court at the remedial stage of proceedings. Accordingly, the State's jurisdictional challenge lies in the first instance with the court of appeals and not with this

Court under 28 U.S.C. § 1253. *See In re Slagle*, 504 U.S. 952, 952 (1992) (White, J., dissenting) ("we narrowly view our appellate jurisdiction in three-judge court cases"). The State did not pursue a timely appeal of the single-judge court's order and it should not be allowed to use the PLRA to end-run the ordinary appellate procedures for challenging a district court decision.

The State contends that the single-judge court's focus on California's "unsuccessful remedial efforts" is inconsistent with the PLRA's requirement that a "prisoner release" be a "remedy of last resort." SJS 15. But that confuses the decision to grant relief with the separate question whether to convene a three-judge court. A three-judge court is appropriately convened when the requesting party submits materials demonstrating that (i) the single-judge court has "previously entered an order for less intrusive relief that has failed to remedy the deprivation" of federal rights; and (ii) "the defendant has had a reasonable amount of time to comply" with those orders. 18 U.S.C. § 3626(a)(3)(A), (C). The single-judge court is thus required by statute to focus on whether previous remedial efforts have proven unsuccessful. In contrast, whether a "prisoner release order" is an appropriate "remedy of last resort" is to be decided by the three-judge court applying different standards. *Id.* § 3626(a)(3)(E). The former question was decided by a single judge and is not appealable directly to this Court. The Court should dismiss the State's first question presented for want of jurisdiction.

2. In all events, a three-judge court was properly convened here. The *Coleman* plaintiffs

filed suit more than 20 years ago seeking to remedy serious constitutional violations occurring in California's prisons. It was not until more than a decade of post-judgment proceedings—with the State failing to cure violations notwithstanding 70 previous court orders—that the *Coleman* plaintiffs moved to convene a three-judge court.

The State suggests that the lower courts acted hastily. But that suggestion cannot be reconciled with the record facts. For example, the State asserts that the *Coleman* "plaintiffs moved to convene a three-judge court only eight months after the district court approved new remedial plans." SJS 15. In fact, the 2006 order was only one of many orders approving refinements in remedial plans that had unsuccessfully governed the State's mental health program for nearly a decade. The State tries to create a similar misimpression by referencing orders issued in June 2006. *See id.* But those orders were likewise part of a succession of (unsuccessful) escalating measures employed since 1997. That the single-judge court continued to issue remedial orders as late as 2006 is not a sign that the State had inadequate time; instead, it is further proof that the court's previous orders were not working.

Significantly, when plaintiffs moved to convene a three-judge court, the single-judge court stayed the matter for six months and sought input from the Special Master, who reported that the few areas of improvement had "succumbed to the inexorably rising tide of population, leaving behind growing frustration and despair." Defs.' Trial Ex. 1292 at 17. Only then did the district court judge request that the three-judge court be convened. As the judge explained, it had "been almost twelve years" since it had found "widespread violations of the Eighth Amendment" and yet the State still had not complied with its basic constitutional obligations. 09-416-App. 297a. The correctness of that decision was confirmed by the State itself. As California's Governor declared: "I don't blame the courts for stepping in to try to solve the health care crisis that we have, the overcrowding crisis that we have, because the fact of the matter is, for decades the state of California hasn't really taken it seriously." Pls.' Trial Ex. 384.

3. The State has no meaningful rejoinder to these points. It instead tries to cast doubt on the seriousness of the ongoing constitutional violations. *See* SJS 15–17; *see also* SJS 23–25, 30-31; IJS 10–11. But the decision to convene a three-judge court does not turn on whether the State may have made "progress." The question is whether previous court orders successfully remedied the ongoing deprivation of federal rights. *See* 18 U.S.C. § 3626(a)(3)(A). The State has conceded that previous court orders have not been successful. SJS 25–26; *Plata*, 2010 WL 1729472, at *8.

Moreover, the State's attempt to re-litigate the underlying constitutional violations is not properly before the Court. The Court has no jurisdiction under 28 U.S.C. § 1253 to determine whether the constitutional violations were properly found by the single-judge courts. Nor should the Court consider factual assertions that were never made below. In the single-judge proceedings, the State did not oppose the motion for a three-judge court on grounds that current conditions satisfied constitutional requirements. *Coleman* D.E. 2063 at 3–9; *Plata* D.E. 579, 600. That was a rational litigation decision because the overwhelming evidence shows, and the State's judicial admissions confirm, that California continues to provide constitutionally inadequate prison medical and mental health care. Constitutional violations continue to this day, caused primarily by the ongoing overcrowding crisis that leaves too few resources being stretched to cover too many prisoners.

II. The Three-Judge Court's Decision To Issue A Remedial Order Complies With The PLRA.

The State contends the three-judge court's order is "contrary to" the PLRA's requirements. SJS 18. But the PLRA affirmatively contemplates that where, as here, a State has failed to resolve constitutional violations, a prisoner release order may be an "[a]ppropriate remedy." 18 U.S.C. § 3626. Such orders are appropriate when (1) crowding is the "primary cause" of the violation of federal rights, and (2) "no other relief" will remedy that violation. *Id.* § 3626(a)(3)(E). The court below found these conditions satisfied. The State's challenge to that finding raises a host of factual issues, but it does not raise any substantial legal questions warranting this Court's plenary review.

A. The Three-Judge Court Properly Applied The "Primary Cause" Requirement.

The State contends that in finding that overcrowding is the "primary cause" of the ongoing constitutional violations, the lower court failed to give "primary cause" its proper meaning. SJS 18. The State's arguments have been forfeited and, in any event, lack merit.

1. The court below adopted *verbatim* the definition of "primary cause" that *the State* proposed: "primary cause" means the "'first or highest in rank or importance; chief; principal.'" Int.App. 78a. That standard is a rigorous one. Unlike a mere "contributing factor" standard—a test discussed in the State's jurisdictional statement that no party proposed and the lower court did not apply—the requirement that crowding be the "first or highest" cause ensures that a court will not issue a remedial order merely because it is "frustrated" with a defendant's failure to correct constitutional violations. SJS 20–21. The State now argues, for the first time, that the PLRA's "primary cause" language requires a showing that the cause is a "proximate and 'but for' cause" of constitutional violations. SJS 19. Because the State did not champion this standard below, the argument is forfeited. *See Sprietsma v. Mercury Marine*, 537 U.S. 51, 56 n.4 (2002).

2. Even if this new argument were not forfeited, it is legally unsupported. "Primary cause" and "proximate cause" are distinct concepts. *See N.Y. Cent. R.R. Co. v. White*, 243 U.S. 188, 205 (1917) (act "disregards the proximate cause and looks to one more remote,—the primary cause"); *United States v. Hatfield*, 591 F.3d 945, 949 (7th Cir. 2010) (Posner, J.) (it "confuses things" to equate primary and proximate cause). Although the terms occasionally overlap, *see In re The G.R. Booth*, 171 U.S. 450, 460 (1898) (proximate cause was "primary"

source of relevant damage), the State offers no authority from the PLRA context or otherwise to suggest that Congress intended to define "primary cause" to mean "proximate cause." *See BedRoc Ltd., LLC v. United States*, 541 U.S. 176, 183 (2004).

3. In any event, even assuming that "primary cause" means a "proximate and 'but for' cause," SJS 19, that standard would be satisfied with clear and convincing evidence. Current and former heads of major correctional systems, including California's, testified that the State could not cure the unconstitutional conditions unless crowding was brought under control. *See* Int.App. 84a ("[o]vercrowding ... is preventing" the State "from providing adequate mental and medical health care to prisoners" (internal quotation marks omitted)); Int.App. 129a (same); Tr. 217–218, 271, 1583. Clinical experts testified to the same effect, explaining that "'[r]educing the population ... is the only way to create an environment in which other reform efforts ... can take root in the foreseeable future.'" Int.App. 168a; *see also* Int.App. 130a. In short, overcrowding is a "but for, proximate" cause of the underlying constitutional violations because it poses a unique, insuperable obstacle to providing adequate medical and mental health care services to prison inmates.

4. The State also contends that a cause is not a "primary cause" of constitutional violations unless eliminating the cause would "undo all or virtually all constitutional harm." SJS 20. But it would subvert Congress's intent (and raise serious constitutional concerns) if a court could not remedy the principal cause of constitutional violations unless relief would

simultaneously resolve every possible deficiency. Indeed, the State's reading would mean that courts' remedial powers are at their *weakest* in the worst prisons, where a multitude of problems have caused the most dangerous conditions. That interpretation of the PLRA makes no sense.

5. The State's real dispute is not with the legal standard applied by the lower court but rather with that court's *fact-intensive* judgment that overcrowding is the "primary cause" of the State's failure to provide constitutionally adequate medical and mental healthcare. Yet the State concedes that overcrowding is *a cause* of the violations. Tr. 2953–2954. Indeed, even the State's expert concedes that overcrowding is the *primary cause* of some violations. Tr. 1092–1094, 1120; Int.App. 138a. The dispute presented is thus only a matter of degree—whether overcrowding is the first or highest cause, or merely a subsidiary cause, of all or only some of the constitutional violations. The lower court's decision is entitled to deference and should be reviewed only for clear error. *See Miller v. Johnson*, 515 U.S. 900, 917 (1995).

The State has not come close to showing that the three-judge court clearly erred. The court's unanimous opinion, which devotes 46 pages to discussing "Crowding As Primary Cause," Int.App. 4a–5a, catalogues the evidence supporting its conclusion that overcrowding is the "primary cause" of the constitutional violations. Int.App. 140a–141a. That conclusion is not some phantom in the eyes of the three-judge court. Four current and former prison administrators from five states, California, Texas, Pennsylvania, Washington, and Maine, all testified that crowding is the primary cause of California's continuing prison deficiencies. Int.App. 81a.

The record demonstrates that severe overcrowding has resulted in living conditions that cause prisoners' mental health to deteriorate. *See* Int.App. 100a–104a, 116a–118a, 121a–123a; *Coleman*, D.E. 3201 ¶¶ 76–87. Overcrowding has impaired the ability of prison personnel to identify and treat prisoners' health care needs. Int.App. 85a–92a. Overcrowding has prevented California from maintaining the essential elements of a functional health care system, including providing basic medications, Int.App. 112a–114a, maintaining accurate medical records, Int.App. 118a–121a, preventing deaths and suicides, Int.App. 123a–126a; *Coleman*, D.E. 3217 at ¶ 173; *Coleman* D.E. 3221 at ¶¶ 100, 109–10, and managing the risk of transmitting infectious diseases. Int.App. 89a, 101a–102a. These deficiencies are compounded by shortages in treatment space, mental health beds, and staff resulting from overcrowded prison populations. *See* Int.App. 85a–89a, 92a–95a, 97a–100a, 104a–112a.

The three-judge court thus drew on clear and convincing evidence in concluding that overcrowding is the first and highest cause—and not simply a subsidiary cause—of the State's inability to provide minimally adequate mental healthcare to inmates. That fact-intensive determination does not justify this Court's plenary review.

B. The Three-Judge Court Properly Concluded That "No Other Relief" Would Remedy The Constitutional Violations.

The State also disputes the three-judge court's determination that "no other relief" would remedy the constitutional violations, listing alternative measures to which it claims the court gave insufficient weight. SJS 22–27. In fact, the lower court carefully considered each proposed alternative and addressed why each was not a viable remedy. Int.App. 145a–168a; *see also* 18 U.S.C. § 3626(a)(3)(E)(ii).

1. The State first contends that the court's analysis is inconsistent with testimony that, in other state prison systems, constitutionally adequate medical and mental health care has been provided in overcrowded prisons. SJS 21–22. But this assertion ignores the extraordinary circumstances of this case, where for more than 15 years under more than 70 orders, California has failed to fix its constitutionally inadequate prison conditions due to unprecedented overcrowding. California's overcrowding crisis is unparalleled, even according to the State's own estimates. Int.App. 56a, 61a–65a, 166a. Experts who inspected the prisons before trial witnessed "almost unheard of" levels of overcrowding. Int.App. 78a; *see also* Tr. 144–145, 270–273, 286–287, 296–298.

2. The State next contends that its commitment to construct new facilities and to hire additional staff rendered the three-judge court's order unnecessary. But the court specifically explained why those commitments did not obviate

the need to impose a prison population cap. Int.App. 145a–155a. In particular, the court cautioned that the mere potential for construction should not itself preclude relief because "the state could, in theory, always build more prisons." Int.App. 146a. It also found that, under the State's proposed timeline, new facilities would not be available for many years. Int.App. 153a–154a. The court similarly found that the State faces "ongoing difficulty in filling vacant positions" and that accommodating significantly more personnel would require space that does not exist. Int.App. 154a–155a.

These findings are well supported. Three years after the State passed a prison building law, AB 900, the State has yet to build any additional prison beds. In 2009, the State failed to fund a healthcare facility that would have provided additional medical and mental health beds. Int.App. 150a. Similarly, the State has not provided funding under AB 900 for in-fill construction projects, and, even if funds were available, the projects included "allocations of clinical space that 'are wildly disparate and, in many cases obviously inadequate.'" Int.App. 151a–152a. Building projects dedicated to mental health treatment have stalled, with completion deadlines pushed years into the future. *Coleman* D.E. 3685, 3736, 3825 ¶ 7, 3825-2 at 99/110 to 102/110, 3841. As the three-judge court found, the State has no "actual, feasible, sufficiently timely" plans for construction in the near future. Int.App. 146a.

3. The State also contends that it could solve the overcrowding crisis by transferring prisoners out of state. If this is true, however, nothing in the three-judge court's order prevents the State from

doing so. Out-of-state transfers are part of the State's approved population reduction plan. St.App. 43a. Indeed, to the extent transfers have the "purpose or effect of reducing" the in-state prison population, any order including transfers is a "prisoner release order" under the PLRA. 18 U.S.C. § 3626(g)(4); Int.App. 159a n.58. The State asserts that the single-judge court limited out-of-state transfers. SJS 26. But the court set no limits on the number of prisoners available for out-of-state transfer; it merely precluded the transfer of seriously mentally ill prisoners. *Coleman* D.E. 2025 at ¶ 5. In fact, the State has steadily increased its use of out-of-state prisons, where it now houses over 8,000 prisoners.

4. Finally, although the State argues that the lower court should have given more time for the *Coleman* Special Master and *Plata* Receiver to remedy the constitutional violations, the three-judge court reasonably found that the Special Master's and Receiver's laudable efforts would continue to fail absent a solution for overcrowding. Int.App. 30a, 49a–52a, 142a, 155a–159a.

The Special Master has repeatedly stated that growing population pressures have largely eliminated any compliance gains made with respect to mental health care. Int.App. 49a–52a (noting "troubling reversal in the progress of the remedial efforts" and "profound impact of population growth"); Defs.' Trial Ex. 1292 at 17. Expert testimony likewise confirmed that any "tentative progress" has been "overwhelmed by the massive population expansion" despite "more than ten years of intensive monitoring and other remedial efforts." *Coleman* D.E. 3221 at ¶ 120; *see also* Tr. 317–318.

C. The Three-Judge Court Based Its Findings On Current Prison Conditions.

The State suggests that the three-judge court's findings are unreliable because the court purportedly assumed that California is not providing constitutionally adequate prison medical and mental health care. SJS 25–26. In particular, it spotlights the three-judge court's rulings concerning the scope of its authority and distorts those rulings into a supposed exclusion of evidence addressing the current state of California's prisons. SJS 25 & n.9; IJS 10.

The State's position is ironic given that, in the proceedings below, it attempted to block prison inspections and moved *in limine* to exclude evidence of current prison conditions. *Coleman* D.E. 2814 at 3, 3101. Its position is also meritless. The three-judge court made clear that it was not barring evidence of current conditions. To the contrary, the evidence would be received "to the extent it illuminates the questions that are properly before the court." Tr. 837. Even the State's counsel recognized the distinction between re-trying the single-judge case and "inform[ing] the court of exactly the impact of overcrowding on the mental health services delivery system" both in the past and "as the population exists today." *Id.*

Contrary to the State's suggestions, it was not barred from presenting evidence from either the *Coleman* Special Master or the *Plata* Receiver. In fact, the three-judge court ordered that the Receiver's most current report, including 15 items requested by the State, be received into evidence. *Plata* D.E. 1450. The State also made extensive use of the Special Master's up-to-date reports. Although it opposed the 2008 prison inspections, the State ultimately sent its experts to inspect the prisons, and their trial testimony was based on their first-hand experience of current prison conditions. *See* Tr. 1072–1138, 1192–1264. The State likewise presented testimony regarding current medical and mental health care expenditures, staffing, and results, *id.* at 725–755, 756–823, 838–945, presumably because plaintiffs' evidence consisted almost entirely of testimony regarding the current state of California's prison medical and mental health care. *See* Tr. 63–137, 293–362, 420–502.

III. The Three-Judge Court's Remedial Order Complies With The PLRA.

Contrary to the State's assertions, the order below is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct" the constitutional violations that continue to cast a dark shadow over California's prisons. 18 U.S.C. § 3626(a)(1)(A). Far from levying a series of rigid mandates, the remedial order affords the State "'wide discretion within the bounds of constitutional requirements.'" *Lewis v. Casey*, 518 U.S. 343, 361–63 (1996).

1. The three-judge court's order strikes an appropriate balance, enforcing the Constitution's "basic ... minimally adequate" standards without unduly interfering with the State's prerogatives.

Coleman, 912 F. Supp. at 1298. Indeed, the order is striking for what it does *not* require. Although a population cap may constitute a "prisoner release order" in a technical sense, the cap does not mandate the release of prisoners or any specific measures. Int.App. 261a. The State has "maximum flexibility" to choose among various options, including providing good time credits; diverting low-level, low-risk offenders and parole violators; increasing rehabilitative programming; constructing new facilities; transferring prisoners out of state; or any other measures that in the State's judgment might address the overcrowding crisis. Int.App. 259a.

The three-judge court's order is consistent with federalism principles. *See Missouri v. Jenkins*, 515 U.S. 70, 98 (1995). The court declined to micromanage the State's financial resources, entrusting the State to address funding issues "under its general responsibilities to the public and in accord with the PLRA." Int.App. 261a. The court also acknowledged that the design capacity benchmarks would not remain "static." Int.App. 262a. It explained, for example, that if the State were to build new facilities, that "increase in design capacity through construction would decrease the number of inmates by which the prison population must be reduced." *Id.*

2. The State contends that the lower court misunderstood the concept of "design capacity." SJS 29–30. But that is not true. The State's arguments regarding design capacity only highlight the nexus between overcrowding and the remedy for constitutional violations. While the State is correct

that housing two inmates in a cell does not violate the Eighth Amendment, it is undisputed that California's prisons were not built to provide adequate medical and mental health care above 100% design capacity. Int.App. 56a–58a; Defs.' Trial Ex. 1007 ¶ 72; Tr. 858–859, 1224. It is not the double-celling or percentage overcapacity by itself that constitutes the violation, but the effect that overcrowding has on the State's ability to provide constitutionally adequate care.

The State also contends that plaintiffs' experts recognized that constitutionally adequate medical and mental health care *could* be provided in certain *other* state prisons where the population exceeds design capacity. SJS 30–32. But there is no evidence that this would hold true in California, and experts were unequivocal that constitutionally adequate care *could not* be provided in California's overcrowded prison system. Int.App. 166a; Tr. 217–218, 259, 286–287. The question for the three-judge court was not whether, in the abstract, limiting a prison population is the only reasonable way to address constitutional violations. Rather, the three-judge court had to deal with the reality of a system overcrowded to extreme levels far beyond the experience of other States, Int.App. 166a; Tr. 270–273, 286–287, 296–298, which consequently could not provide minimally humane levels of care, even after 15 years of other remedial efforts.

The State also contends that there was no basis for setting the 137.5% cap, suggesting that the three-judge court "substituted professional standards and desirable benchmarks for constitutional requirements." SJS 32. But a more stringent cap of 130% comes from a recommendation by the Governor's own prison reform personnel and was supported by testimony from current and former heads of prison systems in California, Texas, Pennsylvania, Maine, and Washington. Int.App. 180a. The court acknowledged that setting a percentage cap could not be an “‘exact science,’” and that its task was “further complicated” by the State's failure to present “any evidence or arguments suggesting that” the court “should adopt a percentage other than 130% design capacity.” Int.App. 175a. Even after finding that a 130% cap “comports with the PLRA,” the three-judge court raised the cap to 137.5% out of deference to the State. Int.App. 169a.

3. For the first time, the State asserts that the lower court's order is overbroad because it potentially affects prisoners outside the plaintiff class—including, for example, prisoners who may not have serious mental health disorders or serious medical conditions. SJS 28–29. But that assertion is a rhetorical innovation conjured up on appeal. At trial, the State rejected targeted relief focused solely on the plaintiff classes, arguing that the three-judge court should *exempt* mentally ill prisoners from any population reduction order. *See* Int.App. 236a. As the State undoubtedly recognized, a targeted mandate would impair its ability to account for whether prisoners are high- or low-risk by reducing the pool of prisoners who could be assessed. *Cf.* Int.App. 224a.

The State nonetheless contends that the cap is improper because it purportedly attempts to ameliorate prison conditions generally rather than remedy constitutional violations unique to class members. *See id.* In fact, the lower court acted consistent with the principles adopted by this Court in *Bounds v. Smith*, 430 U.S. 817, 832–33 (1977), and *Lewis v. Casey*, 518 U.S. 343, 361–63 (1996), by deferring to the State to determine the method by which the population will be reduced and hence which prisoners will be affected. As the court recognized, this approach provides "the deference to state expertise required by the PLRA and *Lewis*" and limits the judiciary's intrusion into "the minutiae of prison operations." Int.App. 175a (internal quotation marks omitted). The State exercised that flexibility by submitting a plan that elected to reduce the prison population for the benefit of all prisoners, not just class members. Int.App. 309a–354a.

The State's reliance on *Hines v. Anderson*, 547 F.3d 915 (8th Cir. 2008), is misplaced. In *Hines*, the court terminated a 1977 consent decree because it was not targeted at a particular constitutional violation. *Id.* at 922. Here, in contrast, the three-judge court acted on clear and convincing evidence of repeated constitutional deficiencies in medical and mental health care caused by overcrowding. Int.App. 163a–164a. Even the Intervenors' expert concurred that "the necessary constitutional medical and mental health services can't be provided with today's overcrowding." Tr. 2202; *see also* Tr. 2190. The fact that a cap may benefit non-class members does not make it any less necessary. *Cf. Davis v. Bd. of Sch. Comm'rs*, 402 U.S. 33, 37–38 (1971) (approving structural reforms impacting non-class members); *Columbus Bd. of Educ. v. Penick*, 443 U.S. 449, 465–68 (1979) (same); *Smith v. Arkansas*

Dep't of Corr., 103 F.3d 637, 645–46 (8th Cir. 1996) (system-wide relief appropriate where injury not remediable on individualized basis).

4. Finally, the State's contention that the three-judge court disregarded public safety distorts the court's decision. SJS 33–34. The court devoted nearly ten days of trial and examined hundreds of exhibits related to public safety, Int.App. 185a, and found that the State "*could* comply with [the] population reduction order *without a significant adverse impact upon public safety.*" Int.App. 187a (second emphasis added). The State stated that it could "safely reach a population level of 137.5%" of design capacity. Int.App. 272a. And the Governor, in presenting his proposal to the State legislature, declared that a reduction of 37,000 prisoners could be accomplished safely in two years. *See Plata* D.E. 2258 Ex. B (Matthew Cate, *Prisons: It's Time to Reform and Reduce the Population*, Capitol Weekly, Aug. 13, 2009); *see also* Tr. 2984–2985.

The State suggests that crime rates may spike absent significant investment in effective rehabilitation. SJS 33; IJS 18–19. Not true. The overwhelming empirical evidence shows no significant relationship between crime rates and early release. Int.App. 243a–246a. Dozens of jurisdictions throughout the country have safely implemented reductions in prison and jail populations without witnessing increases in recidivism or crime. Int.App. 202a–203a, 243a–246a. Similarly, numerous county jails in California release prisoners to maintain capacity around or below 100% due to safety concerns and/or court-imposed population caps. Int.App. 224a–227a &

n.84, 202a–203a. Moreover, as the court explained, the States' substantial savings from a manageable prison population could be redirected towards "rehabilitative and reentry programming in the prisons" and community re-entry programs, which have been shown to *promote* public safety. Int.App. 187a, 235a.

* * * *

The three-judge court's narrowly tailored order complies with the PLRA. It is admittedly an unusual order, but this is an unusual case. As the lower court determined, the "'future injury and death' of California prisoners is 'virtually guaranteed in the absence of drastic action.'" Int.App. 170a (quoting *Plata* D.E. 371). After 20 years of continuing constitutional violations that, despite more than 70 previous court orders, the State has failed to remedy, the State should not be allowed to further delay taking actions to address overcrowding that it concedes can be safely implemented within two years. Because the extreme circumstances of this case are unlikely to recur and because the order below presents no substantial legal questions, the Court should affirm the lower court's decision.

CONCLUSION

For these reasons, the Court should dismiss or summarily affirm the decision below.

Respectfully submitted,

May 14, 2010

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MOTION

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Nos. 09-1232 and 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et. al.*,

Appellants,

and

CALIFORNIA STATE REPUBLICAN LEGISLATOR INTERVENORS, *et. al.*,

Appellants,

v.

MARCIANO *PLATA* AND RALPH *COLEMAN*, *et. al.*,

Appellees.

Appeal from the United States District Courts
For the Eastern District of California and
The Northern District of California

PLATA APPELLEES' MOTION TO DISMISS OR AFFIRM

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QUESTIONS PRESENTED

1. Whether the Court's jurisdiction under 28 U.S.C. § 1253, which extends to orders "granting or denying ... an interlocutory or permanent injunction" rendered "by a district court of three judges," authorizes direct review of a single-judge district court's decision to convene a three-judge panel.

2. Whether the three-judge court clearly erred in concluding that the conditions for a prison population cap under 18 U.S.C. § 3626(a)(3)(E) were satisfied based on its fact-intensive determinations (i) that prison overcrowding is the primary cause of California's failure to provide inmates with constitutionally adequate mental and medical healthcare, and (ii) that, in light of numerous unsuccessful previous court orders spanning years of failed remedial efforts, "no other relief" would remedy the ongoing constitutional violations.

3. Whether the three-judge court's order requiring California to bring its prison population to within 137.5% of its prisons' total design capacity, while affording State officials broad discretion to choose which remedial measures will safely and effectively address the prison overcrowding crisis, is narrowly drawn, extends no further than necessary, and is the least intrusive means necessary to correct the ongoing violations of inmates' federal constitutional rights.

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MOTION TO DISMISS OR AFFIRM

Pursuant to Rule 18.6, the *Plata* appellees move for a partial dismissal of the appeal because this Court lacks appellate jurisdiction over a challenge to a decision by a single-judge district court. Appellees further move to affirm the order below because the questions raised are so insubstantial that no further argument is warranted. For the reasons set forth below and for the additional reasons set forth in the motion to dismiss or affirm filed by the *Coleman* appellees, the Court should summarily affirm the lower court's decision.

INTRODUCTION

This appeal arises from an order requiring the State of California to reduce its prison population because no other remedy will prevent further serious injury and death in California's dangerously overcrowded prisons.

There can be little dispute about the essential facts underlying the three-judge court's decision. After proclaiming a "Prison Overcrowding State of Emergency" four years ago, the defendant Governor recently concluded that California's prison system is now so overcrowded that it is "collapsing under its own weight." His counsel conceded that medical care in the prisons continues to be so inadequate as to violate the Eighth Amendment.

In response to the prison crisis, the Governor has repeatedly urged the state legislature to reduce the prison population, most recently by proposing measures to reduce the population by 37,000 prisoners over two years, and in frustration expressed a true understanding of why judicial relief is necessary:

> I don't blame the courts for stepping in to try to solve the health care crisis that we have, the overcrowding crisis that we have, because the fact of the matter is, for decades the state of California hasn't really taken it seriously. It hasn't really done something about it.

Ex. P-384, Trial Tr. 650-51.

After concluding a lengthy trial in this case, the three-judge court found that overwhelming evidence establishes that overcrowding is the "primary cause" of the Eighth Amendment violations and that no other remedy could succeed without a reduction in the population.

In its appeal, the State raises the question of whether a federal court can impose a narrowly tailored prison population cap under these circumstances. The answer must be affirmative.

Congress expressly authorized federal courts to remedy unconstitutional prison conditions by imposing a cap on the population of correctional facilities. 18 U.S.C. § 3626(a)(3). As directed by Congress, the three-judge court imposed the population reduction order on California's prisons only as a last resort, after decades of judicial (and political) efforts to remedy the constitutional violations proved unsuccessful, and only after it exhaustively studied the potential impact of its order on public safety and found that the order would not have substantial adverse consequences.

The court's order to reduce the prison population is supported by the former head of California's prison system and by witnesses who have run or are currently running state prison systems in Texas, Pennsylvania, Washington State and Maine. All of these officials testified for the plaintiffs, some for the first time and two without compensation. All affirmed that overcrowding was the primary barrier to the operation of a minimally adequate health care system in California. Four other correctional health care experts – one testifying for defendants – joined that chorus of opinion.

The State asserts here that the lower court strayed far from its federal role when it imposed a population cap. But the State's portrayal of the lower court's decision is inaccurate; the court's 183-page opinion reveals a remarkably different picture from that depicted in the Jurisdictional Statement. It is a picture of a court that used every other remedy in its power before even considering imposing a population cap; that repeatedly delayed its rulings in the vain hope of voluntary action by the State; that took its responsibilities to protect constitutional rights seriously while protecting the State's political prerogatives; and that fairly surveyed the vast and overwhelming evidence before issuing the order on appeal.

The State claims correctly that the order to reduce the prison population by about 38,000 prisoners over a two year period is significant.[1] But, like much in the State's brief, this assertion lacks context. California has one of the largest prison systems in the world, currently housing 165,000 prisoners. Every month it releases on parole more than 10,000 prisoners. And although it may seem counter-intuitive, the evidence overwhelmingly proves that releasing more low-risk prisoners on parole will not increase crime. The length of incarceration is not related to recidivism; thus, literally millions of other prisoners have been released "early" at the same time that the crime rate has been dropping to the lowest level in decades.

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[1] The State exaggerates when it claims that the order requires a reduction of 46,000 prisoners. In its filings in the district court, it cited the figure of 40,000, State-App. 32a, and with the current population level, the correct figure is 38,246. *See*

(continued)

The lower court's opinion in this case is not, as the State suggests, policy reform hidden in judicial clothing. It is a straightforward application of the rules set by Congress to a unique set of facts that can bear no other conclusion.

The lower court's detailed opinion makes that clear, but so does the State's brief. Instead of arguing that the factual findings are clearly erroneous, the State picks a few points in its favor while ignoring all of the overwhelming evidence that supports the findings. Instead of remaining true to its definition of a key phrase ("primary cause") in the controlling statute that the lower court adopted verbatim at its request, the State suggests a new one on appeal that is contrary to the statute's plain language. Instead of proposing a viable alternative to population

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http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad100421.pdf. The figure would be even smaller if the State builds new prison facilities.

reduction, the State suggests the receivership as a remedy while it simultaneously argues in the Ninth Circuit in this very case that Congress prohibited such a remedy when it enacted the Prison Litigation Reform Act.

The three-judge court did what Congress told it to do in these circumstances. After finding that crowding was the primary cause of the constitutional violations, and that no other relief would provide a remedy, the court granted relief. Its order was consistent with both the governing statute and this Court's opinions requiring that the relief be narrowly tailored and the least intrusive means to remedy the constitutional violations. The court set the population cap under a time frame the State determined it could meet, and it gave the State complete freedom to determine how to comply with that order.

The order below does not present any substantial questions warranting this Court's plenary review, and should be summarily affirmed.

JURISDICTION

This Court has jurisdiction over the State's and Intervenors' appeals from the injunction issued by the three-judge court pursuant to 28 U.S.C. § 1253, but lacks jurisdiction over the State's challenge to the single-judge court decision to convene the three-judge court, State J.S. 11-18.

STATEMENT OF THE CASE

1. This appeal arises out of two separate actions to remedy unconstitutional health care in the prisons, *Plata v. Schwarzenegger*, a case filed on

behalf of prisoners with serious medical needs, and *Coleman v. Schwarzenegger*, a case filed on behalf of prisoners with serious mental disorders.

The *Plata* plaintiffs filed suit in 2001 claiming that the State fails to provide constitutionally adequate medical care. Int. App. 13a. In 2002, the State agreed to a settlement, conceding that the prison conditions are unconstitutional and that judicial oversight is necessary under the PLRA. *Plata* D.E. 68, ¶29.

Following the settlement, the *Plata* court issued other supplemental orders aimed at improving the quality of care and governance of the prison medical system. Int. App. 14a-30a. However, "defendants proved incapable of or unwilling to provide the stipulated relief." Int. App. 14a. "Three years after entering into the consent decree, not a single prison had successfully implemented the remedial procedures, despite the fact that a 'significant number' of inmates had died as a direct result of substandard medical care – a fact the State openly acknowledges." *Plata v. Schwarzenegger*, No. 09-15864, 2010 WL 1729472 at *2 (9th Cir. Apr. 30, 2010).

Ultimately, the court appointed a receiver to oversee prison medical care. Int. App. 29a-30a. Even the Receiver could not remedy the constitutional violations. Int. App. 30a.

The reason constitutional violations have persisted for years despite intensive judicial oversight is straightforward: prison overcrowding. Int. App. 30a, 141a-142a.

The prisons were built to house 80,000 prisoners. Int. App. 57a. They now house double that number.

Int. App. 9a. Some prisons are crowded to 300% of capacity. Int. App. 10a. No other state faces a comparable crisis.

In 2006, Governor Arnold Schwarzenegger declared a "Prison Overcrowding State of Emergency" because, he said, the severe prison crowding "has caused substantial risk to the health and safety of the men and women who work inside these prisons and the inmates housed in them" making prisons places of "extreme peril to the safety of persons." 09-416-Appellees'-App. 2a, 14a.

The Governor further declared that "immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding." Int. App. 61a. The state of emergency is still in effect. Int. App. 62a.

The most visible consequence of crowding is the prisons' overuse of so-called "ugly" beds—more than ten thousand double and triple bunks "crammed into gyms and dayrooms that were never meant to be used for housing." Int. App. 100a (citation omitted); *see also* 09-416-Appellee-App. 19a-23a (photographs of ugly beds). The former head of the Texas prison system testified that "'[i]n more than 35 years of prison work experience, I have never seen anything like it.'" Int. App. 100a.

According to a former high-ranking California prison official: "the risk of catastrophic failure in a system strained from severe overcrowding is a constant threat.... [I]t is my professional opinion this level of overcrowding is unsafe and we are operating on borrowed time." Int. App. 84a-85a.

Nowhere is this risk of catastrophic failure felt more acutely than in the health care system. The health care infrastructure is simply unable to deal with the vast number of prisoners:

- *Crowding Causes Deadly Delays in Emergency Response.* Because of the extremely overcrowded living conditions, it can be nearly impossible for prison staff to identify or respond adequately to medical emergencies. Int. App. 110a-111a; Trial Tr. 380:1-381:7, 382:14-383:3. A former head of California's prison system described how a prisoner was assaulted in the middle of a crowded gymnasium converted to overflow housing. Because the gym was so crowded, prison staff didn't even know about the injury – much less provide emergency medical aid – until after the victim had already died. Trial Tr. 382:2:-383:3 (Woodford).

- *Lack of Space to Deliver Health Care.* The three-judge court found that "[o]ne of the clearest effects of crowding is that the current prison system lacks the physical space necessary to deliver minimally adequate care to inmates." Int. App. 85a. Indeed, as the Receiver has reported, "'the available clinical space is less than half of what is necessary for daily operations.'" Int-App. 93a (citation omitted). A former Secretary of California prisons testified that "the lack of space is not only a housing issue, but it's impacting other factors, like delivery of healthcare services, the lack of offices, and clinical space." *Plata* D.E. 1992-10 at 5 (Tilton).

- *Increased Lockdowns Due to Crowding Impede Access to Care.* Because the prisons are so overcrowded, inmate control is difficult, and prison administrators rely heavily on lockdowns to exert control. Int. App. 116a-117a. During lockdowns, prisoners are unable to leave their housing units to go to health clinics; instead, medical staff must go cell-to-cell to see prisoners. Int. App. 117a-118a. This causes serious delays in access to care, and results in inadequate care. Int. App. 116a-188a.

- *Crowding Results in Inadequate Screening of New Prisoners.* Prison reception centers, where prisoners are processed on arrival, are so crowded that they have no place to properly screen new prisoners. As a result, prisoners' "health needs are not identified" and "cannot be treated. In addition, inmates whose needs are not identified may be placed in a setting that will exacerbate existing but unidentified health problems." Int. App. 89a; *id.*, 87a-88a.

- *Spread of Infectious Diseases.* As the Governor proclaimed, overcrowded living conditions cause an "increased, substantial" risk of transmission of infectious diseases. 09-416-Appellees'-App. 2a; Int. App. 101a-102a.

- *Shortages of Health Care Staff.* Because the prisons are overcrowded, there are simply too few health care practitioners to address the basic needs of prisoners. Int. App. 104a-109a. While the prisons have improved their staffing levels from their former rock-bottom levels, the overcrowded prisons continue to provide such dismal working conditions that the prisons remain unable to recruit or retain enough staff. Int. App. 154a. And even if enough staff could be recruited, they would have almost nowhere to work, because of the lack of space in the overcrowded prisons. Int. App. 154a-155a.

- *Overwhelmed Medication Management Systems.* The sheer number of prisoners housed in institutions built for half their number has overwhelmed the prisons' medication management systems. As a result, the prisons are unable to deliver the right medication to the right prisoner in a timely manner. Int. App. 112a-114a.

- *Overwhelmed Medical Records Systems.* Overcrowding has also overwhelmed the prisons' medical records systems, so that the prisons cannot identify what health care services a prisoner may need. Int. App. 118a-121a.

- *Overburdened Specialist Referral Systems.* Overcrowding has also eclipsed the prisons' ability to provide urgent specialty medical care to prisoners who need it. Int. App. 114a-116a.

- *Prisoners Are Dying From Inadequate Care.* As a direct result of all of these problems caused by crowding, there are "unacceptably high numbers of both preventable or possibly preventable deaths, including suicides, and extreme departures from the standard of care." Int. App. 123a.

According to the Receiver, "[i]t will not be possible to raise access to, and quality of, medical care to constitutional levels with overpopulation at its current levels." Ex. P-55 at 1, *Plata* D.E. 1757 at 10. As recently as January 2010, the Receiver reported to the court that the "prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care." *Plata* D.E. 2289-1 at 6.

2. In November 2006, after the Governor issued the "Prison Overcrowding State of Emergency Proclamation," plaintiffs filed a motion to convene a three-judge court to consider population reduction remedies. Int. App. 62a-63a.

The court delayed hearing the motion in order to give the Receiver an opportunity to report about the impact of overcrowding on his remedial efforts, and urged the State to use the delay to remedy the problems on its own. Int. App. 63a.

Ultimately, the Receiver reported that crowding stymies his remedial efforts. Exs. P-26, Int. App. 86a; P-27; D-1292, Int. App. 41a. The State, meanwhile, failed to develop other remedies.

On July 23, 2007, the *Plata* and *Coleman* courts issued separate orders requesting that a three-judge court be convened. Int. App. 65a. The Ninth Circuit Court of Appeals ordered, without objection, that a single three-judge court be convened to consider both cases. Int. App. 69a.

The three-judge court stayed discovery and delayed consideration of this matter for more than seven months, referring the matter to a settlement referee to give the State another opportunity to resolve the crowding problem on its own. Int. App. 69a-70a. The State again failed to do so.

3. Commencing on November 18, 2008, the lower court held fourteen days of trial and two days of closing argument. Int. App. 70a. The court heard testimony from nearly 50 live witnesses and more by written testimony, and admitted hundreds of documents into evidence. *Id.* Testifying in favor of a population reduction order was the former head of the California prison system, and the current and former heads of state prison systems in Texas, Pennsylvania, Washington State, and Maine. Int. App. 81a n.44.

On August 4, 2009, the court issued an opinion and order finding that plaintiffs have demonstrated all elements required by the PLRA for issuance of a "prisoner release order." Int. App. 253a-254a.

The court found that "clear and convincing evidence establishes that crowding is the primary cause of the unconstitutional denial of medical and mental health care to California's prisoners." Int. App. 82a.

The court also found and concluded that "[r]educing the population in the system to a manageable level is the only way to create an environment in which other reform efforts, including strengthening medical management, hiring additional medical and custody staffing, and improving medical records and tracking systems, can take root in the foreseeable future." Int. App. 168a (citation omitted).

In other words, the court found, "all other potential remedies will be futile in the absence of a prisoner release order." Int. App. 144a-145a.

4. The court then addressed appropriate relief. Relying on testimony from State prison officials, county jail administrators, the former head of the California prison system, and the former heads of the Texas, Pennsylvania, Washington State, and Maine prison systems, the court concluded that "a cap of no higher than 137.5% is necessary." Int. App. 169a, 175a-185a.

The court gave substantial consideration to potential impacts of the reduction in the prison population, and found that the evidence shows that "the state *could* comply with [its] population reduction order without a significant adverse impact upon public safety or the criminal justice system's operation." Int. App. 187a-188a.

In developing a population reduction plan, the State "would not be required to throw open the doors of its prisons, but could instead choose among many different options or combinations of options for reducing the prison population." Int. App. 173a-174a. Such measures have already been proposed by the Governor, and overwhelming testimony affirms that such measures "either have no impact" on the recidivism rate "or reduce the recidivism rate" and therefore "would not adversely affect public safety." Int. App. 249a; *see also* Int. App. 196a-220a.

5. The State has conceded that it is possible to "safely" reduce the prison population. Int. App. 272a. On November 12, 2009 the State submitted a plan to gradually reduce its prison population using the well-accepted, safe methods examined by the three-judge court, among others. State-App. 32a-70a. In its plan, the State set forth six-month population reduction benchmarks that it would meet during the process of achieving the required population reduction within two years. *Id.* 70a.

6. On January 12, 2010, the three-judge court issued a final order requiring the State to reduce its prison population. The court issued the narrowest and least intrusive remedy available to it under the circumstances; it ordered the State only to meet the six-month population benchmarks set forth in the State's plan, but gave the State free reign to choose which population reduction measures to use. State-App. 3a-6a.

THE QUESTIONS PRESENTED ARE NOT SUBSTANTIAL

The appeals in this unique, fact-bound case do not have any of the indicia traditionally warranting plenary review: there is no circuit split, no important question of law, and no serious dispute about any of the important facts. The State avers that a summary affirmance by this Court will have a profound precedential effect, but the singular circumstances of the prison crowding in California, and the fact-specific nature of the issues raised by the appeals, will greatly reduce any impact of a summary affirmance, which in any event would be afforded "less deference" than other orders of this Court. *Ashland Oil, Inc. v. Caryl*, 497 U.S. 916, 920 n*(1990); *see also Caban v. Mohammed*, 441 U.S. 380, 390 n.9 (1979) (same); *Gonzales v. Automatic Employees Credit Union*, 419 U.S. 90, 95 (1974) ("in the area of statutory three-judge-court law the doctrine of stare decisis has historically been accorded considerably less than its usual weight").

This case is not about whether the State is currently violating the Eighth Amendment rights of appellees. The State has already admitted that there are current constitutional violations and that while it challenges particular remedies, it does not seek to terminate judicial oversight. *Plata v. Schwarzenegger*, No. 09-15864, 2010 WL 1729472 at *8-9 (9th Cir. Apr. 30, 2010); *Plata*, No. 09-15864 (audio recording of oral argument, Sept. 16, 2009, at http://www.ca9.uscourts.gov/media/view_subpage.php?pk_id=0000003923, at minutes 9:53-10:13).

The State also concedes that the inadequacies in the medical care system are caused in part by prison crowding. Trial Tr. 2953:6-2954:5 (closing argument). It concedes that the State has long proven unable to remedy the problems on its own, and it admits that federal court intervention is reasonable. Ex. P-384.

The State nonetheless claims that the lower court erred in its findings of fact, but the matters it raises are not substantial:

While it admits that the *Plata* court had previously issued orders for less intrusive relief over a period of eight years, the State disputes the court's finding that the State had a "reasonable" amount of time to comply with the earlier orders.

While it admits crowding is one cause of the constitutional violations, the State disputes the lower court's finding that crowding is the "biggest" cause.

While it agrees that crowding imperils the health of inmates, it challenges the finding that crowding must be reduced for the State to remedy the constitutional violations.

While it admits that it can safely reduce the population by the amount ordered, the State argues that the lower court's ruling will jeopardize public safety.

On each of these matters, the lower court's determinations must be upheld because there was no clear error. Fed. R. Civ. P. 52(a)(6); *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 948 (1995).

I. The Three-Judge Court Was Properly Convened.

A. The Appeal Must Be Dismissed.

This Court must dismiss the part of the State's appeal that argues that the single-judge court erred when it recommended that the three-judge court be convened. This Court lacks jurisdiction over this matter on direct appeal because the decision by the single-judge court is neither "an order granting or denying" an injunction, nor is it one "required by any Act of Congress to be heard and determined by a district court of three judges." 28 U.S.C. § 1253. The *Plata* appellees join in and rely upon the argument set forth in the *Coleman* Plaintiffs' Motion to Dismiss or Affirm, Nos. 09-1232, 09-1233, at 18-19.

B. The State's Claims Are Meritless.

Even if the Court were to reach the substance of the State's claims, those claims do not warrant plenary review. The lower court has "previously entered" multiple orders for "less intrusive" relief, and a "reasonable amount of time" has surely elapsed, as it is undisputed that the passage of eight years has not sufficed to remedy the violations. 18 U.S.C. § 3626(a)(3)(A).

In 2002, by stipulation, the *Plata* court entered an injunction designed to ensure minimally adequate medical care. *Plata* D.E. 68. Since that time, the *Plata* court has undertaken extensive and extraordinary efforts to effectuate a remedy, as described more fully in *Plata,* 2010 WL 1729472. However, "defendants proved incapable of or unwilling to provide the stipulated relief." Int. App. 14a.

In 2004, "after two years of little progress, the parties entered into a Stipulated Order Regarding the Quality of Patient Care and Staffing . . . which the court promptly approved." *Plata,* 2010 WL 1729472 at *2.

That too proved ineffective. One year after the State entered the quality of care stipulation, and "[t]hree years after entering into the consent decree, not a single prison had successfully implemented the remedial procedures . . ." *Id.* In the face of the unrelentingly dismal level of medical care, which was admittedly killing a "significant number" of prisoners, the *Plata* court conducted proceedings to determine whether to impose a receivership to oversee the remedial effort. *Id.*

At the hearing on that matter, "[n]umerous experts testified as to the 'incompetence and indifference' of prison physicians and medical staff and described an 'abysmal' medical delivery system where 'medical care too often sinks below gross negligence to outright cruelty.'" *Id.* The State was unable to rebut this evidence, "candidly admit[ting]" that "'to date [it had] failed to attain compliance with all aspects of [prior] Court orders.'" *Id.*

Ultimately, the *Plata* court found it necessary to appoint a receiver to oversee prison medical care, which appointment became effective in 2006. *Id.*

It is true, as the State asserts, that plaintiffs *filed* their motion to convene the three-judge court seven months after the Receiver was appointed. What the State fails to mention is that the single-judge court did not *convene* the three-judge court for more than a year after the Receiver was appointed, and it did so only after the Governor had proclaimed that prison crowding constitutes a state of emergency that imperils prisoners' health, Int. App. 61a, and the Receiver had reported to the court that crowding-related problems "are now assuming a size, scope and frequency that will clearly extend the timeframes and costs of the receivership and may render adequate medical care impossible . . ." Ex. P-27 at 10.

The *Plata* court found that the conditions for convening a three-judge court had been met because "the Receiver will be unable to eliminate the constitutional deficiencies at issue in this case in a reasonable amount of time unless something is done to address the crowded conditions in California prisons," 09-146 State App. 286a, and "'[t]he Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed.'" *Id.* 279a (citation omitted); *see also id.* 281a-282a.

The State has made no showing that the *Plata* court's factual findings are clearly erroneous. To the contrary, the passage of time has proven the court right on all counts. It is now fully four years since the Receiver first took office, and the Receiver has still been unable to remedy the conceded constitutional violations because of crowding. *See Plata* D.E. 2289-1 at 6 (Receiver's report).

II. The Three-Judge Court Correctly Found That Crowding Is The Primary Cause Of The Constitutional Violations And That No Other Relief Would Remedy Them.

A. The Definition Of "Primary Cause."

As the State acknowledges, the three-judge court *adopted verbatim* the definition of "primary cause" proposed by the State below: the "cause that is 'first or highest in rank or importance; chief; principal.'" Int. App. 78a-79a; State J.S. 19. The State is thus judicially estopped from challenging this definition here. *See New Hampshire v. Maine*, 532 U.S. 742, 749-750 (2001).

Moreover, the State did not contend below that the definition adopted by the court was error, nor did it ever argue before the three-judge court that "primary cause" means the "but for" or "proximate cause," as it argues here. The State is thus barred from raising these new contentions on appeal. *Taylor v. Freeland & Kronz,* 503 U.S. 638, 646 (1992).

Even if the Court could consider a legal argument that is both contrary to the party's contention below and raised for the first time on appeal, the new standard proposed by the State cannot be reconciled with the plain text of the statute. The statute uses the term "primary cause," not "but for" cause or "proximate cause." The Court must presume that Congress meant what it said, and may not impose a different standard here.

The State also contends that crowding cannot be the primary cause of the violations because other factors contribute to the constitutional violations (and so, according to the State, "curing crowding would not remedy the alleged violations"). State J.S. 19. But as the three-judge court correctly found, the PLRA's use of the term "primary" to modify "cause" indicates that Congress understood that there can be multiple causes. Int. App. 79a. And indeed, the State acknowledges that to satisfy the statute crowding need not be the "only" cause, it must simply be the "biggest cause." Trial Tr. 2960:12-15 (closing argument). Even the State's proposed definitions of primary cause – "but for" cause and "proximate" cause – presume the possibility of other, lesser causes. Thus, the State's argument that a factor cannot be the "primary" cause if there are other causes fails as a matter of logic.

Nor is there any requirement, as the State suggests, that curing crowding must by itself remedy all the violations. Any such rule would raise serious questions about the statute's constitutionality, because it would prohibit courts from remedying the main cause of a constitutional violation unless the relief would simultaneously resolve all deficiencies. Congress did not prohibit courts from granting relief from overcrowding unless that remedy alone would cure all constitutional deficiencies, and its use of the term "primary cause" recognizes the possibility of multiple contributing causes, and, accordingly, multiple types of relief.

The three-judge court put it succinctly: "The PLRA does not require that a prisoner release order, on its own, will necessarily resolve the constitutional deficiencies. . . . All that the PLRA requires is that a prisoner release order be a necessary part of any successful remedy. If all other potential remedies will be futile in the absence of a prisoner release order, 'no other relief will remedy the violation.'" Int. App. 144a (quoting 18 U.S.C. § 3626(a)(3)(E)(ii)). The statute is satisfied when a prisoner release order is *necessary* regardless of whether it is in itself *sufficient* to remedy the violation. Int. App. 134a.

Nonetheless, as a practical matter, eliminating crowding will satisfy the State's proposed standard that the remedy must "undo all or virtually all" of the constitutional violations. State J.S. 20. The *Plata* court has already appointed a receiver and issued numerous orders aimed at improving medical care, through, e.g., "recruitment and retention of qualified personnel, medical leadership, medical equipment, screening systems, systems to track patients with needs, record keeping, and institutional culture." State J.S. 20-21. As the evidence bore out, once the crowding is reduced the Receiver and the State will be able to implement the court orders already in effect, and to correct the ongoing constitutional violations. *See* Int. App. 158a-159a.

B. The "Primary Cause" Findings.

In the proceedings below, the State conceded that the inadequacies in the medical care system are caused in part by prison crowding. Trial Tr. 2953:6-2954:5 (closing argument). The only question, then, is the degree to which crowding – as opposed to other factors – is causing the violations.

That is a question that the trial court is uniquely positioned to answer, and which the lower court resolved based on the voluminous record, and overwhelming testimony below.

One former head of California's prison system testified that she "absolutely believe[s]" the primary cause of the medical deficiencies is overcrowding. Int. App. 126a. The former head of Texas prisons agreed, as did the top corrections officials from Pennsylvania, Washington and Maine. Int. App. 126a-128a.

The current and two past directors of California's prison system all concede that crowding adversely affects nearly every aspect of prison operations, including the provision of health care. Int. App. 82a-84a; Trial Tr. 1683:11-20, 1684:5-16; *Plata* D.E. 1714-14, ¶ 3.

That consensus reflects the reality that the unprecedented level of overcrowding in California prisons is an insuperable obstacle to solving the problems of constitutionally deficient mental and physical health care.

As the court found, and the State does not contest:

- Crowding causes potentially deadly delays in emergency response. Int. App.110a-111a.
- Crowding increases the transmission of infectious diseases. Int. App. 101a-102a.
- Having too many prisoners for the prison infrastructure has crippled the prisons' ability to provide the right medication to the right prisoner. Int. App. 112a-114a.
- The sheer number of prisoners has overwhelmed the prisons' medical records system. Int. App. 118a-121a.
- There are not enough medical facilities to provide medical care to the vast number of prisoners who need it. Int. App. 85a-95a.

- There is no place to properly screen the tens of thousands of new prisoners to see if they have serious medical conditions. Int. App. 87a-89a.
- There are not enough beds to house medically-needy prisoners in appropriate settings. Int. App. 95a-97a.
- There are not enough medical staff to treat the vast number of prisoners, the overcrowded unsanitary conditions make it impossible to recruit enough new staff, and even if new staff were hired there would be no space for them in the prisons. Int. App. 154a-155a.
- There are not enough medical specialists to treat the large number of prisoners who urgently need specialty care. Int. App. 114a-116a.
- Crowding-caused lockdowns lead to serious delays in providing medical care. Int. App. 116a-118a.
- Crowding contributes to an unacceptably high number of prisoner deaths. Int. App. 142a.

The lower court summed up the evidence this way: "[t]he crushing inmate population has strained already severely limited space resources to the breaking point, and crowding is causing an increasing demand for medical and mental health care services, a demand with which defendants are simply unable to keep pace." Int. App. 140a.

As the court found, the "only conclusion that can be drawn from the wealth of clear and convincing evidence . . . is that the unconstitutional denial of adequate medical and mental health care to California's inmates is caused, first and foremost, by the unprecedented crowding in California's prisons." Int. App. 143a. Neither appellant claims that these findings are clearly erroneous.

C. The "No Other Relief" Findings.

Closely related to the finding that crowding is the "primary cause" of the constitutional violations is the three-judge court's conclusion that "no other relief" will remedy the violations. Int. App. 144a-145a.

The court canvassed the various proposals for "other relief" that were presented by the State and Intervenors, as well as all other evidence on the subject, and concluded that "clear and convincing evidence" establishes that "the constitutional deficiencies in the California prison system's medical and mental health system cannot be resolved in the absence of a prisoner release order." Int. App. 145a.

The State points to various other "remedies" that it suggests could have improved medical care even without a reduction in the prison population, but never claims that the three-judge court's detailed factual findings on each subject were clear error. None of its claims raise a substantial question warranting plenary review.

1. Receiver. The State's claim that the Receiver is "other relief" that could remedy the violations lacks merit.[2]

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[2] It is also ironic. Just after the trial below was concluded, the State sought to terminate the Receivership (and the (continued)

The three-judge court canvassed the Receiver's efforts, and lauded the work he has done to improve the medical system. *See, e.g.*, Int. App. 30a, 155a-156a, 158a. But despite four years of the Receiver's best efforts, and despite the State's insinuation to the contrary in its brief, the State has conceded that constitutional violations remain. *Plata,* 2010 WL 1729472 at *8-9; *Plata,* No. 09-15864 (audio recording of oral argument). And the three-judge court correctly found that "a reduction in the present crowding of the California prisons is necessary if the efforts of the *Plata* Receiver and the *Coleman* Special Master to bring the medical and mental health care in California's prisons into constitutional compliance are ever to succeed. In the absence of a prisoner release order, all other remedial efforts will inevitably fail." Int. App. 158a-159a.

The State's position is that this Court should ignore all the evidence supporting the trial court's findings, and rely instead on cherry-picked testimony taken out-of-context from plaintiffs' experts that the State claims undermines plaintiffs' case. Not only is that an improper approach to adjudicating this fact-bound question, but the State is wrong on the facts.

Receiver's remedial plans) on the grounds that both are forms of relief prohibited by the PLRA. *Plata,* 2010 WL 1729472. Either the Receiver fits within the definition of "relief" that a court may order under the PLRA (18 U.S.C. § 3626(g)(9)) and that a three-judge court must consider as an alternative a prisoner release order, or it is not "relief" that a court may enter under the PLRA, and must be terminated. The State cannot have it both ways.

Contrary to the State's assertion, plaintiffs' experts do not undermine the "no other relief" finding.

Plaintiffs' medical expert, a former consultant to California and a federal court receiver for the District of Columbia Jails' health care system, testified that the Receiver "will be unable to address and resolve the critical medical care deficiencies until the need for services within the system is significantly reduced." *Plata* D.E. 1714-13 at ¶¶3, 136.

The current Secretary of Corrections in Pennsylvania, who was chosen by the State of California to sit on its own expert panel, testified that reducing the population is "the only way" to fix the inadequacies. Trial Tr. 1583:15-22; Ex. P-2 at ii.

The former Secretary of Corrections in Pennsylvania, Washington and Maine, who is also a member of the State of California's expert panel, testified that as a result of the "overwhelming" crowding, the Receiver will be unable to remedy the violations. Trial Tr. 270:25-272:13.

Other correctional experts, including the former director of the Texas prison system, and Intervenors' independent expert, agreed. Trial tr. 153:7-11, 180:3-11 (Scott); *see also* Trial Tr. 2190:16-2191:2, 2201:24-2202:6 (Defendant-Intervenor expert).

Even a former *Plata* defendant who was acting Secretary of California's prison system testified that unless the State reduced overcrowding, it would "never" be able to provide or sustain constitutionally adequate medical or mental health care. Trial Tr. 385:3-10.

That some of the experts agreed that it *may* hypothetically be possible to provide health care in crowded prisons does not undermine their ultimate conclusions, based on the concrete facts on the ground in California, that California's unprecedented level of overcrowding makes adequate care impossible. Trial Tr. 286:9-287:1; Trial Tr. 270:25-272:13; Trial Tr. 492:21-25.

2. Hiring. The three-judge court correctly found as a matter of fact that additional hiring, without reducing crowding, would be ineffective. Int. App.154a-155a. The court extensively canvassed all the hiring evidence produced by the parties, Int. App. 105a-112a, and found that it is unlikely the State will be able to hire enough medical and custodial staff under current conditions: despite extensive efforts, there has been a "serious and ongoing difficulty in filling vacant positions," Int. App. 154a, which is due in part to the fact that "working conditions for such personnel in California's overcrowded prisons are uninviting, and many potential staff members are unwilling to work under them." *Id.*

Furthermore, the court found that "[e]ven if staff could be hired, they would have almost nowhere to work because CDCR's facilities lack the physical space required to provide medical and mental health care." Int. App. 154a-155a. No party claims that these factual findings are erroneous.

3. Out-of-State Transfers

The State wrongly contends that the three-judge court erred in "rejecting the possibility" of expanding the number of out-of-state transfers. State J.S. 26. As the three-judge court found, ordering the State to transfer more prisoners out-of-state is not an *alternative* to a prisoner release order, it is an order that would *constitute* a prisoner release order. Int.

App. 159a n.58 (18 U.S.C. § 3626(g)(4) defines "prisoner release order" as one that "directs the release from . . . *a* prison"). Indeed, the State's population reduction plan incorporates precisely this measure. State-App. 60a-61a.

4. Construction

The State claims that it might be able to alleviate prison crowding through construction. The court's order takes this into account; the State can achieve the necessary reduction in crowding through construction, population reduction, or some combination of the two. Int. App. 262a.

Nonetheless, as the court found, the State has proven utterly unable to accomplish its prison construction goals. Int. App. 149a-154a. The construction plan on which the State hangs its argument – AB 900 – was part of a measure approved in 2007, and yet not a single prison bed has been built now, fully three years later. Int. App. 150a. And the State itself sought to terminate and delay the Receiver's plan to construct medical facilities. *Plata*, 2010 WL 1729472 at *10. The court correctly found, based on this track record, that construction is not a viable alternative to a court order because of the delays associated with prison construction. Int. App. 145a-154a. The State does not claim that the court's conclusions regarding delay were error.

D. The Findings Are Based On Current Evidence

1. There are current, ongoing violations of the plaintiffs' constitutional rights. The State has admitted this fact, and concedes the necessity of

judicial oversight. *Plata,* 2010 WL 1729472 at *8-9. Yet the State nonetheless peppers its brief with insinuations, explicit and implicit, that it has fixed the problems, and the court's involvement in prison medical care is an unwarranted intrusion into state affairs. The problem is that such contentions lack any *factual* support.

Thus, for example, the State complains that it was prohibited from gathering and introducing evidence relevant to whether the constitutional violations are "'current and ongoing.'" State J.S. 19; *see also* Int. J.S. 6. Such argument is simply inconsistent with the State's concession that there are current and ongoing violations. In any event, neither the State nor Intervenors identify a single item of evidence that was excluded. That is because all that the three-judge court limited was the legal questions it would answer, which are prescribed by statute.

Under the PLRA, the proceedings in the three-judge court were solely about whether to order the State to reduce prison overcrowding; the questions whether there is a constitutional violation in the first place, and whether prospective relief should be maintained or terminated, are questions reserved to the single judge district courts. 18 U.S.C. §§ 3626(a), (b), (e). Accordingly, the three-judge court correctly held that it did not have authority to re-determine the underlying liability question. State App. 77a-78a.[3] No party contests this legal conclusion.

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[3] The three-judge court invited the State, if it contended that the constitutional violations had been remedied, to bring that matter before the single judge district courts in an (continued)

That does not mean, however, that evidence about current conditions was excluded. The State introduced voluminous documentary evidence – as well as percipient and expert testimony – about current conditions within the prisons in connection with its contentions that crowding is not the primary cause of the violations and that other relief will remedy the violations.

State experts toured the prisons weeks before trial, examined prison medical facilities, interviewed medical personnel, prison staff and prisoners, and testified about the conditions they found. *See, e.g.*, Exs. D-1016, D-1017, D-1019, Int. App. 82a, D-1020; Trial Tr. 1071-1143, 1191-1253. The State introduced exhibits with current health care statistics, medical and mental health care staffing levels, and institutional populations. *See, e.g.*, Exs. D-1233; D-1149, D-1259-1, D-1235-2; Trial Tr. 1272:12-21. The State also introduced the reports of the *Coleman* Special Master and the *Plata* Receiver, which include extensive discussion of current conditions. *See, e.g.*, Exs. D-1087-D-1100, Int. App. 150a, D-1106, D-1224-1231, D-1110-1112, D-1292, Int. App. 41a, D-1293, D-1294, D-1108, Int. App. 49a. State witnesses presented exhaustive testimony about current conditions, including the extent of overcrowding, staffing levels, the use of ugly beds, medication management problems, health care expenditures, and prisoner deaths. *See, e.g.*, Exs. D-1000-1002, D-1004-1008, Trial Tr. 836-944, 1891-

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appropriate proceeding. Pretrial Conf. Tr. 28-29 (Nov. 10, 2008); *see also* 18 U.S.C. § 3626(b). The State has not done so.

1940, 1668-1709, 1734-1772, 755-823, 724-754; *Plata* D.E. 1990-4 at 4-7.

Nor was the State precluded from gathering evidence about current conditions in the prisons. State officials control the prisons and its documents and information; the State's experts had full access to tour the prisons, to talk to prison medical staff, and to review all relevant data and information in the possession of the prison medical staff and Receiver. *See, e.g., Plata* D.E. 1453 at ¶¶ 2-5 & Ex. A; *Plata* D.E. 1453 1624-12 at 1; *Plata* D.E. 1453 1624-8 at 1-2.[4]

2. The State also complains that it was unable to take a deposition of the Receiver to ascertain his "views on whether a prisoner release order was necessary." State J.S. 24. But that is a legal conclusion, well beyond the scope of discovery of a lay witness. And to put it mildly, this kind of a discovery dispute hardly raises a "substantial question" for this Court to review. *See, e.g., Wayte v. U.S.*, 470 U.S. 598, 624-625 (1985) (Marshall, J., dissenting) (abuse of discretion standard applies to discovery disputes, which "acknowledges that appellate courts in general, and this Court in particular, should not expend their limited resources making

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[4] The State makes the absurd contention – never raised below – that the evidence is not "current" because the court set a date for a discovery cutoff, and did not consider post-trial evidence. State J.S. 25. In every case, trial courts must limit discovery and limit the record to evidence properly presented at trial. The State makes no showing that the limits imposed below were erroneous.

determinations that can profitably be made only at the trial level.")

In any event, pursuant to court order, the Receiver reported to the court his views about the impact of crowding on the delivery of medical care. Exs. D-1092-1095. The State cites no authority for the contention that it was entitled to discovery against a judicial officer concerning matters put in those court-ordered reports.

Furthermore, the State suffered no prejudice. The State has not disputed a single fact in any of the voluminous reports the Receiver has issued– many of which the State itself introduced into evidence. *See, e.g.*, Exs. D-1087-D-1100, D-1106, D-1108, D-1110-1112, D-1224-1231. Indeed, the State does not point to one fact that it could have gained from a deposition that would have changed the result in this case; it did not make an offer of proof on any point; and it did not even seek to have the Receiver testify as a trial witness. *See, e.g., Plata* D.E. 1724 (Pretrial Conf. Sta.).

What is more, the State was able to obtain the fifteen specific items of data from the Receiver that it proclaimed were the "best evidence" of the current "status of the delivery of medical care and the Receiver's plans for implementing improvements in medical care." *Plata* D.E. 1436. The Receiver issued a public report that provided each item of data requested by the State, and the court held that such report would be admissible at trial. *Plata* D.E. 1450.

III. The Order Below Provides The Least Intrusive Means To Remedy The Constitutional Violations, And Is Narrowly Tailored.

The State's contentions about the remedy fail because the three-judge court's order is the least intrusive means to remedy the ongoing constitutional violations and is narrowly tailored precisely to maximize the State's remedial discretion. The *Plata* plaintiffs join in the *Coleman* plaintiffs' motion to dismiss or affirm as to these matters. *Coleman* Plaintiffs' Motion to Dismiss or Affirm, Nos. 09-1232, 09-1233 at 31-37.

IV. The Three-Judge Court Gave Substantial Weight To Public Safety Considerations.

The contentions that the lower court erred by failing to give "substantial weight" to public safety concerns fail to raise a substantial question for this Court to review. Only by a false reading of the statute and the opinion below can the State argue that the lower court erred.

1. The State argues that the lower court's order failed to meet a test that is not found in the statute. JS at 33. It states that the court's order must provide "substantial protection to the public." *Id.* (citing legislative history). The statute, however, is more nuanced; for any relief that courts may issue in prison conditions cases, the court must "give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." 18 U.S.C. § 3626(a)(1)(A).

The State implies that the lower court was blind to public safety by issuing an order that would increase crime absent a substantial investment in "'evidence-based rehabilitative programming.'" State J.S. 33. That is not true. After spending dozens of pages discussing the "Potential Population Reduction Measures and Their Impact on Public Safety and the Operation of the Criminal Justice System," the three-judge court reiterated how seriously it took this review and concluded as follows: "[W]e are confident that a prison population reduction to 137.5% design capacity can be achieved in California without a *substantial meaningful adverse impact on public safety or the operation of the criminal justice system.*" Int. App. 248a (emphasis added).

To support this conclusion the court relied on the report by the State's selected panel of experts,[5] the conclusion of a corrections panel chaired by former Governor Deukmejian, testimony by Intervenor law enforcement witnesses and the experience of other jurisdictions across the country. Int. App. 248a-255a.

The court did not find, as the State suggests, that reducing the population without expanding rehabilitation would harm public safety. On the contrary, it found that the lack of programming is the status quo (the State currently releases more than 10,000 prisoners every month without providing meaningful rehabilitation. Int. App. 128a-129a), and increasing rehabilitative programs would "increase public safety above its current level, including after issuance of [the] population reduction order." Int. App. 253a.

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[5] The State, directly contradicting its own federalism theme, makes the remarkable claim that it is "unreasonable" to rely upon the recommendations made by its own experts because the State now faces a new "financial condition." State J.S. 34. But, as the court correctly found, "[a]lthough California's prison population could be reduced without adopting or strengthening such local programs, the benefit to the State of investing in them would be considerable. Whether or not to make such an investment, however, is . . . *a matter for state officials, not the court, to decide.*" Int. App. 235a (emphasis added); *see also* Int. App. 252a-253a (same).

The State admits that it can "safely reach a population of 137.5%" of design capacity. Int. App. 272a; 09-416 State J.S. 11. The Governor declared that such a reduction could be accomplished safely in two years. *Plata* D.E. 2258 at 5-7 (current head of California prisons explains Governor's plan to reduce prison population by 37,000 over two years); Trial Tr. 2984:7-2985:15.

The State's expert, as well as the Intervenors, conceded that there are methods for the State to reduce the prison population without adversely impacting public safety. *See, e.g.*, Trial Tr. 1995:8-20 (State's public safety expert); Trial Tr. 3044:7-9, 3045:5-12 (Law Enforcement Intervenors' closing argument); Trial Tr. 3022:24-3023:11 (District Attorney Intervenors' closing argument); Trial Tr. 3063:10-24 (San Mateo County Intervenors' closing argument); Trial Tr. 1007:21-1008:4 (Intervenor San Diego County Deputy District Attorney); Trial Tr. 1052:4-1053:9 (Intervenor Stanislaus County Chief Probation Officer); Powers Report § III (same); Trial Tr. 2770:23-2771:10 (Intervenor Yolo County Chief Probation Officer); *Plata* D.E. 1664 ¶¶ 56-79 (Intervenor Sonoma County corrections expert); *Plata* D.E. 1667 at 5-6 (same); *Plata* D.E. 1711 ¶¶16-20

(Intervenor San Diego District Attorney); *Plata* D.E. 1745, ¶¶17-27 (Intervenor Los Angeles County Sheriffs' Department, Director of Bureau of Operations for Bureau of Offender Programs and Services); *Plata* D.E. 1698, ¶ 3 (Intervenor San Mateo County Chief Probation Officer).

The well-accepted population reduction methods cited by the court include providing additional "good time" credits to prisoners for good conduct and for participation in work or education programs, Int. App. 196a-204a, diverting low-risk technical parole violators and low-level, low-risk offenders away from prison, Int. App. 209a, 204a-208a, 210a-214a, and expanding rehabilitative programs. Int. App. 214a-216a.

Having made these well-supported findings, the three-judge court deferred to the State to design the precise contours of its population reduction program.

2. Intervenors contend that the court "does violence" to the PLRA by delegating to the State the responsibility to develop a remedial plan. Int. J.S. 16. Yet Intervenors do not address – much less contest – the three-judge court's conclusion that it must defer to the State's proposed population reduction measures, consistent with this Court's decisions in *Bounds v. Smith*, 430 U.S. 817, 832-833 (1977) and *Lewis v. Casey*, 518 U.S. 343, 361-363 (1996). Int. App. 172a-173a.

Intervenors also complain that the court erred when it "disregarded" opinions of certain Intervenor witnesses that the court found to be not credible. Int. J.S. 18. The trial court, however, is uniquely situated to make such determinations, and its findings "based on determinations regarding the credibility of witnesses" demand great deference and "can virtually never be clear error." *Anderson v. Bessemer City*, 470 U.S. 564, 575 (1985). Intervenors offer no argument to justify disturbing this rule of deference.[6]

Intervenors hyperbolically claim that by failing to heed their warnings the three-judge court has "virtually assure[d] that . . . crime will spike in California as a result of the Prisoner Release Order." Int. J.S. 18-19. There is no support in the record for such a claim. There is, however, ample support in the record for the opposite conclusion. Dozens of jurisdictions throughout California and the nation have implemented prison population reductions; none have experienced an increase in recidivism or crime. Trial Tr. 2103:20-2105:5-21; 2107:15-2108:17;

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[6] Intervenors' contention is further undermined by the gross distortions in their own witnesses' testimony. For example, one Intervenor declared that a prison population reduction would make his crowded jail overflow, costing the county millions of dollars to transfer jail inmates to other counties; he was forced to admit, however, that his methodology was flawed (Trial Tr. 1794:19-22), his jail is not in fact overcrowded (Trial Tr. 1791:6-12), and no inmates would need to be sent out of county. Numerous other Intervenor witnesses made similar exaggerations. *See, e.g., Plata* D.E. 1922 ¶¶ 6-8 (admitting that estimate of cost to county was wildly overblown, in one instance by a factor of more than twenty); Trial Tr. 2272:1-2273:6, 2276:5-18, Ex. P-841 (exaggerating impact on jails); Trial Tr. 2677:7-2680:7, *Plata* D.E. 1727 ¶¶ 23, 26 (witness had no idea how he came up with exaggerated figures showing impact on jails); *Plata* D.E. 1728 ¶ 33 (similar exaggeration); Trial Tr. 1819:9-1830:3, 1830:21-1831:23 (exaggerating the impact on LA county jails); *Plata* D.E. 1726 ¶¶ 26-27, Trial Tr. 2706:21-2707:5 (exaggerating the impact of a population reduction on prosecutors' ability to try cases).

2108:19-2109:1, 2110:6-2111:8, 2111:10-21, 2112:17-20 (Dr. Krisberg).

Similarly, historical data shows that the crime rate does not increase when the incarceration rate drops. *Plata* D.E. 1714-3 at ¶¶ 19-26; Trial Tr. 2160:20-2162:7 (Dr. Krisberg); *see also* Ex. P-842, Trial Tr. 2815, 2842.

Pursuant to the PLRA's requirement, the three-judge court gave "substantial weight" to potential impacts on public safety, and devoted more than fifty pages of its opinion to that question. Int. App. 185a-256a. The court carefully reviewed the testimony and evidence presented by Intervenors, State defendants, and plaintiffs, and correctly concluded that the evidence "overwhelmingly showed that there are ways for California to reduce its prison population without . . . an adverse impact [on public safety], and that a less crowded prison system would in fact benefit public safety and the proper operation of the criminal justice system." Int. App. 248a-249a. Neither the State nor Intervenors demonstrate that this was clear error.

* * *

The State casts its appeal in the broadest terms possible, invoking grand principles of federalism and judicial activism. The issues actually raised in its Jurisdictional Statement, however, belie these grandiose claims. There are, in fact, no substantial legal disputes. Essentially, the State disputes some of the trial court's findings of fact. And even there, the State's contentions merely peck around the edges of the three-judge court's well-reasoned 183-page opinion that is based on the overwhelming, largely uncontested evidence in the voluminous record below.

The three-judge court issued the order on appeal cautiously, after all other efforts employed by the lower courts to remedy the constitutional deficiencies had been failing for years, and after the Governor, the head of California's prison system, and the court-appointed Receiver all agreed that the prison crowding crisis in California poses a serious and immediate threat to prisoners' lives.

Appellants' appeals fail to present substantial questions warranting plenary review, and this Court should summarily affirm the decision below.

CONCLUSION

For the foregoing reasons, and for the reasons set forth in the *Coleman* Appellees' Motion to Dismiss or Affirm in Nos. 09-1232 and 09-1233, the appeals should be dismissed or the order below should be affirmed.

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OPPOSITION
BRIEF

No. 09-1233

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

CONSOLIDATED OPPOSITION TO APPELLEES' MOTIONS TO DISMISS OR AFFIRM

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RULE

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CONSOLIDATED OPPOSITION TO APPELLEES' MOTIONS TO DISMISS OR AFFIRM

The State's Jurisdictional Statement presents substantial questions arising under the Prison Litigation Reform Act ("PLRA"). It asks this Court to decide whether the requirements for convening a three-judge court to consider a "prisoner release order," J.S. 11-18, were satisfied; and, if properly convened, whether the three-judge court misinterpreted and misapplied 18 U.S.C. § 3626(a)(3)(E) in issuing the order under review. J.S. 18-27. In addition, the remedy imposed is independently worthy of plenary review because, *inter alia,* the district court acknowledged that its release order "'extends further than the identified constitutional violations'" to the plaintiff-classes, *id.* at 28, contravening the text of 18 U.S.C. § 3626(a)(1)(A). Moreover, in conflict with this Court's holdings, the court used professional benchmarks, not the minimum standards of the Eighth Amendment, to determine the scope of relief ordered. J.S. 30-34.

If this Court does not grant review, the State must reduce its prison population by at least 38,000-plus inmates. Compare *Plata* Mot. 3-4 n.1, with J.S. 2 n.2. No matter how the State implements the order, it must reduce the prison population by a startling amount. Thus, the substantial legal questions presented by this "prisoner release order" have profound practical consequences and public importance.

In response, appellees assert that a petition for certiorari would not be granted in this matter and therefore that the decision below should be summarily affirmed. *Coleman* Mot. 17-18, 1; *Plata* Mot. 14-15, 21, 36-37. But the considerations animating this Court's discretionary review play no role here. In important contrast to the denial of a petition for certiorari, this Court's summary affirmances are precedential decisions that bind the lower courts. See Sup. Ct. R. 18.12; *Hicks* v. *Miranda*, 422 U.S. 332, 344-45 (1975); cf. *Plata* Mot. 14. The case for review of this appeal is uniquely powerful because it involves a "prisoner release order" under the PLRA. After significantly narrowing this Court's general appellate jurisdiction in 1988, see Pub. L. No. 100-352, 102 Stat. 662, Congress *expanded* the Court's mandatory jurisdiction to include prisoner release orders when it enacted the PLRA. Congress plainly understood that any "prisoner release order" case would involve a lengthy record of litigation over alleged violations of prisoners' federal rights. Thus, the extensive record that appellees treat as a warrant for summary affirmance instead is a reason that Congress expected this Court to engage in plenary review in precisely this type of case.

In all events, this case is inappropriate for summary affirmance. As shown, it presents significant, unresolved issues of statutory construction. Moreover, what appellees call an "admittedly unusual" order, *Coleman* Mot. 16, 37, mandates a result that Congress would not have imagined when it enacted the PLRA. The court imposed the most drastic relief ever ordered in a prison conditions case despite, *inter alia*, the State's continuing progress in remedying constitutional violations, the concession by appellees' experts that constitutional compliance likely has been achieved at particular facilities, and the State's ongoing development of solutions for overcrowding and improvement of prison conditions generally. This Court should grant plenary review.

I. THE FIRST QUESTION PRESENTED IS PROPERLY BEFORE THE COURT AND IS SUBSTANTIAL.

Appellees claim that the Court cannot consider the first question presented because "[t]he State did not pursue a timely appeal of the single-judge court's order and it should not be allowed to use the PLRA to end-run the ordinary appellate procedures for challenging a district court decision." *Coleman* Mot. 18-19; *Plata* Mot. 16. Appellees are wrong on the law and misrepresent the record.

The State timely appealed the orders convening the three-judge court to the Ninth Circuit. See J.S. 6 n.4. In contradiction of their position now, appellees then argued that those orders were *not* appealable to the Ninth Circuit because they "d[id] not resolve a 'collateral' matter separate from the merits of the action," but instead "[we]re 'directly intertwined' with the ultimate claims in the cases." Mot. Dismiss 14, No. 07-16361 (9th Cir. Aug. 19, 2007). Appellees asserted that "the Orders will be fully reviewable if and when the three-judge court were to *issue relief such as an injunction or a prisoner release order*," *id.* (emphasis added), knowing full well that this Court has exclusive jurisdiction over any such appeal. The court agreed and dismissed the appeal. *Coleman* v. *Schwarzenegger*, No. 07-16361, 2007 WL 2669591 (9th Cir. Sept. 11, 2007) (per curiam).

In these circumstances, this Court should not permit Appellees to disavow their prior contentions. See *New Hampshire* v. *Maine*, 532 U.S. 742, 749-51 (2001) (discussing judicial estoppel).

Estoppel aside, the merits of a properly convened three-judge court's "prisoner release order" are within this Court's exclusive appellate jurisdiction. Thus, this Court can reach the underlying question of whether the three-judge court had authority to enter such relief. *Gully* v. *Interstate Natural Gas Co.*, 292 U.S. 16, 18-19 (1934) (per curiam); see generally *Gross* v. *FBL Fin. Servs., Inc.*, 129 S. Ct. 2343, 2348 n.1 (2009) (discussing anterior questions). In *Gully*, after a three-judge district court was statutorily convened, this Court reversed the entry of injunctive relief without reaching the decree's merits because the three-judge court was improperly convened:

> [T]his Court by virtue of its appellate jurisdiction in cases of decrees purporting to be entered pursuant to [the statute requiring a three-judge district court], *necessarily has jurisdiction* to determine whether the court below has acted within the authority conferred by that section and to make such corrective order as may be appropriate ....

292 U.S. at 18 (emphasis added); *id.* at 19 (remanding to single-judge court for further proceedings); *accord Gonzalez* v. *Automatic Employees Credit Union*, 419 U.S. 90, 95 n.12 (1974).

Finally, the decisions to convene a three-judge court present substantial issues. Both held that a court can rely on an earlier period of regression or frustration with the pace of the statutory remedies to convene a three-judge court even where, as here, the State is currently making progress under less intrusive remedial orders. See J.S. 12-13, 15. This exceedingly broad interpretation of Congress's command that the defendant be afforded "a reasonable amount of time to comply with the previous court orders" is incorrect. 18 U.S.C. § 3627(a)(3)(ii). The district courts instead should have considered, *inter alia*, the impact of the remedies newly imposed by the Receiver in *Plata*, who, like plaintiffs' experts, has concluded that his plan of action will remedy all the alleged constitutional violations without resort to prisoner release. J.S. 12-14, 21 n.7, 23.

The appellees' mistake lies in their heavy focus on earlier periods in the litigation. See, *e.g.*, *Coleman* Mot. 20 (referencing "more than 20 years" of litigation and "measures employed since 1997"); *Plata* Mot. 17 (discussing 2004 stipulation and Receiver's 2006 appointment). Appellees' attempt to frame this litigation through *Plata* D.E. 371—the findings of fact and conclusions of law underlying the October *2005* appointment of the Receiver—is illustrative. See *Coleman* Mot. 2. That order, like others appellees cite, does not speak to the State's subsequent progress under the Receiver and the Special Master. See, *e.g.*, J.S. 13 (Receiver's praise for accomplishments in 2009 and 2010).

Appellees respond that "the State fails to mention ... that the single-judge court did not *convene* the three-judge court for more than a year after the Receiver was appointed." *Plata* Mot. 17-18. But, as the State pointed out, the Receiver filed his "Plan of Action" just *two months* before the three-judge court was convened. J.S. 12. The progress under that plan has been substantial, and the Receiver and plaintiffs' experts attest that it will remedy the alleged constitutional violations. *Id.* at 12-14, 23; see also *id.* at 16-17 (progress under Special Master).

II. THE REMAINING QUESTIONS PRESENTED INVOLVE SUBSTANTIAL ISSUES.

Appellees recognize that the second and third questions presented are properly before this Court, but argue that this case is too fact-bound for plenary review. This contention is incorrect for the reasons stated *supra* at 1-2, and those that follow.

1. Although appellees characterize the State's challenge to the court's interpretation of "primary cause" as disagreement with a "*fact-intensive* judgment," *Coleman* Mot. 25, the district court concluded that "'the primary cause issue is ultimately a question of law.'" 09-416-App. 126 n.55. And, appellees implicitly concede that there exists no uniform interpretation of the term "primary cause" and its relationship to proximate causation. Compare *Coleman* Mot. 23-24, with J.S. 19-20.

Appellees' claim (*Coleman* Mot. 24) that there is "no authority ... to suggest that Congress intended" to incorporate a proximate cause requirement into the standard is incorrect. Pre-PLRA, courts required showings that prison overcrowding proximately caused the alleged violations of plaintiffs' federal rights. See, *e.g.*, *Carver* v. *Knox County*, 887 F.2d 1287, 1294 (6th Cir. 1989); *Marsh* v. *Barry*, 824 F.2d 1139, 1143 (D.C. Cir. 1987) (per curiam); *Abrams* v. *Hunter*, 910 F. Supp. 620, 627 (M.D. Fla. 1995), *aff'd*, 100 F.3d 971 (11th Cir. 1996).[1]

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[1] Appellees also assert that the State forfeited its statutory construction, *Coleman* Mot. 23, or is estopped from advancing it, *Plata* Mot. 19. As to forfeiture, it is well-established that "[p]arties are not confined here to the same arguments which were advanced in the courts below upon a Federal question there discussed." *Dewey* v. *Des Moines*, 173 U.S. 193, 198 (1899); *accord Yee* v. *City of Escondido*, 503 U.S. 519, 534-35 (1992). Moreover, the State's interpretation of "primary cause" here is not inconsistent with its arguments below. *Compare Coleman* Mot. 23 (relying on *Sprietsma* v. *Mercury Marine*, 537 U.S. 51, 56 n.4 (2002) (respondent "waived" its argument that federal maritime law governed by arguing below that state law applied)). Finally, because the State did not prevail below,

Furthermore, appellees' arguments that the record contains "clear and convincing" evidence that overcrowding is the "primary cause" of the alleged constitutional violations are baseless. See *Coleman* Mot. 25-26; *Plata* Mot. 21-23. Appellees claim that numerous experts "testified that crowding is the primary cause." *Coleman* Mot. 25-26. However, they overlook the district court's acknowledgement that the experts' testimony constituted legal conclusions, 09-416-App. 126 n.55, and they fail to refute the State's demonstration that plaintiffs' experts' legal conclusions lacked foundation. See J.S. 30-32 & n.11. As shown, plaintiffs' experts failed either to analyze what level of care was being provided or to tether their opinions about the consequences of overcrowding to the Eighth Amendment's requirements. See *id.*; see also *Coleman* Mot. 26 (discussing "prison deficiencies" rather than "deliberate indifference" resulting in "unnecessary and wanton infliction of pain").[2]

---

judicial estoppel is irrelevant. *New Hampshire*, 532 U.S. at 750-51.

[2] Appellees suggest that the testimony of a State expert, Dr. Packer, is conclusive on whether overcrowding constitutes the "primary cause" of alleged constitutional violations. *Coleman* Mot. 10. But, as the district court acknowledged, Dr. Packer "testified that, with one exception, crowding was *not* the primary cause of the constitutional violations." 09-416-App. App. 138a (emphasis added); *see id.* at 166a (other improvements could remedy the problems even if crowding persisted). Additionally, Dr. Packer's testimony that crowding was the primary cause of deficiencies at reception centers does not indicate that crowding is the primary cause of the alleged Eighth Amendment violations unless one wrongly assumes that reception center shortcomings by themselves constitute unconstitutional care.

2. The interpretation and application of § 3626(a)(3)(E)(ii) also presents substantial questions worthy of review. Like the court below, appellees read out of the statute the requirement that the prisoner release order "remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E)(ii).

Appellees claim that although the prisoner release order is not "in itself *sufficient* to remedy the violation," it purportedly "is *necessary*" to such a remedy. *Plata* Mot. 21. Their premise is wrong. As the State showed, the Receiver concluded that his plan would remedy all alleged constitutional violations without population controls, see J.S. 12-14; and plaintiffs' experts conceded that (i) the Receiver could provide constitutional levels of care at the current population, (ii) constitutional care may already have been achieved at certain facilities notwithstanding crowding, and (iii) the Receiver's plan would "'ensure'" constitutional care. *Id.* at 23. Appellees' experts' claims of necessity are doubly flawed because they are linked to the propriety of the care provided, and not its constitutionality. *Id.* at 30-32.

Appellees again highlight the State's struggles at earlier points in this litigation, but those prior struggles do not alter this analysis. See, *e.g.*, *supra* at 4-5; *Coleman* Mot. 29; *Plata* Mot. 27. For instance, appellees recognize that their experts conceded that they had administered similarly crowded prison systems while delivering constitutionally adequate care, J.S. 21-22 (populations over 200% design capacity), and that the State showed that some of CDCR's most crowded facilities provide the best care, *id.* at 23-24. But, appellees believe that the district court rightly ignored these facts due to the "extraordinary circumstances of this case, where for more than 15 years under more than 70 orders, California has failed to fix its constitutionally inadequate prison conditions." *Coleman* Mot. 27.[3] Both appellees and the court ignored the State's commitment to improving mental health and medical care under the current administration and its well-documented successes. Doing so was error.

3. The scope of the prisoner release order alone justifies plenary review.

Appellees do not directly respond to the State's demonstration (J.S. 29-33) that they failed to show that either the 130% cap plaintiffs requested or the 137.5% cap imposed constituted the reduction necessary to cure the alleged *Eighth Amendment* violations. Appellees cite evidence that California's prisons were not built to provide medical and mental health care at populations above 100% design capacity, *Coleman* Mot. 33. They fail, however, to identify evidence showing that at 100% design capacity, the prisons provide care that is only minimally adequate under the Eighth Amendment or that above 100% design capacity, the care violates the Eighth Amendment. Appellees further suggest that the Governor's prison reform study supported a 130% cap, *id.* at 33-34, but again fail to cite any evidence that those recommendations were directed at satisfying constitutional *minima* rather than the more demanding professional standards. See 09-416-App. 183a-184a ("[W]e cannot determine from the evidence whether the national standard selected by the Governor's strike team represents a judgment *regarding the mandates of the Constitution or whether it merely reflects a policy that ensures desirable prison conditions*.") (emphasis added). Plaintiffs have the burden of showing that the injunctive relief requested is tailored to the violations established. These shortcomings are, accordingly, fatal. See J.S. 33-34; *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979) ("scope of injunctive relief is dictated by the extent of the violation established," an issue on which movant carries the burden).

---

[3] Appellees' suggestion that the court's findings were based on similar evidence regarding *current conditions* does not withstand examination. *See Plata* Mot. 28-31. They point to four court findings, *see id.* at 30 (citing Int. App. 82a, 150a, 41a, 49a), but those pertain to: the *Coleman* trial held in *1994*, Int. App. 41a; evidence as of 2006, *id.* at 49a; testimony regarding conditions in 2007 that has no connection to alleged unconstitutional conditions, *id.* at 82a ("crowding 'affects virtually every aspect of a prison's operation'" and prevents "'*thoughtful decision-making and planning*'") (emphasis added); and construction planning that is not relevant to their argument, *id.* at 150a. Appellees' related claim that the State sought to limit evidence of current unconstitutional conditions is misleading. *Coleman* Mot. 30. The State resisted duplicative discovery that would have interfered with trial preparations, *Coleman* D.E. 2814, at 3, and sought to preclude the introduction of evidence of "overcrowding, housing, or other environmental conditions affecting the general population" rather than evidence of health care that violates the Eighth Amendment. *Coleman* D.E. 3101, at 2.

Additionally, the PLRA requires that any prisoner release order extend "*no further* than necessary to correct the violation of the Federal right of a *particular plaintiff* or *plaintiffs*," 18 U.S.C. § 3626(a)(1)(A) (emphases added); and this Court has imposed similar limitations on equity, see J.S. 29. The district court, however, acknowledged that it was granting an order that "*extends further* than the identified constitutional violations" to the plaintiff-classes. 09-416-App. 172a (emphasis added). In light of this admission, the order violates the PLRA.

Appellees, however, argue that the "discretion" that the court gave the State in implementing the prisoner release order cures any defects in its tailoring. See *Coleman* Mot. 31-32, 34-35; *Plata* Mot. 36. It does not. For instance, appellees' claim already has been belied by an order issued by Judge Karlton of the three-judge court. See App. 13a. Applying the three-judge court's ruling, the *Coleman* court held that it would not approve a housing plan affecting the class-members "as long as [it] calls for a projected population in excess of 137.5% of the facility's design capacity." *Id.* The 137.5% cap thus does not operate systemwide with a two-year phase-in period. Instead, it is an immediate ceiling upon the State's discretion to manage particular correctional facilities.

Finally, there is no merit to appellees' claims that the State invited any erroneously overbroad relief by failing to propose a specific population cap and by suggesting that class-specific relief was inappropriate. *Coleman* Mot. 34. It was plaintiffs' burden, not the State's, to prove that the remedy was adequately tailored. The State's view, like that of the Receiver and some of plaintiffs' experts, is that any constitutional violations that persist can be remedied without a prisoner release order. Second, the State never asserted that "targeted relief" would be inappropriate. *Id.* (citing Int. App. 236a). Indeed, neither appellees nor the order on which they rely identifies any such assertion by the State. Instead, the State argued that release of seriously mentally ill inmates was likely to create special dangers because of their recidivism rates. *Plata* D.E. 2031 ¶¶ 109-111; Tr. 1770, 2517-18. Doing so does not constitute an opposition to all targeted relief. Clearly, such relief would have been less intrusive than the order on appeal.

CONCLUSION

The Court should note probable jurisdiction (or reserve the jurisdictional question), deny the motions to dismiss and for summary affirmance, and hear the case on the merits.

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JOINT
APPENDIX

FOR ARGUMENT

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GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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and in the Appellants' Appendix to the 09-1233 Jurisdictional Statement at the following pages:

Coleman v. *Schwarzenegger/Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK-JFM-P, C01-1351-TEH (E.D. Cal./N.D. Cal. Jan. 12, 2010) (order to reduce prison population) 1a

Coleman v. *Schwarzenegger/Plata* v. *Schwarzenegger*, No. 2:90-cv-00520 LKK-JFM-P, (E.D. Cal. Jan. 4, 2010) (order applying population cap) 11a

Notices of Appeal to the Supreme Court of the United States, *Coleman* v. *Schwarzenegger/Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK JFM P, C01-1351 TEH (E.D. Cal./N.D. Cal. Jan. 19, 2010) 17a

Population Reduction Plan (E.D. Cal./N.D. Cal. Nov. 12, 2009) 25a

U.S. DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA -
Live System (Sacramento)

Civil Docket For Case #: 2:90-cv-00520-LKK-JFM

COLEMAN *et al.*

v.

SCHWARZENEGGER *et al.*

RELEVANT DOCKET ENTRIES

Date Filed	#	DOCKET TEXT
07/25/1991	60	AMENDED COMPLAINT by plaintiff Ralph Coleman; adding Winifred Williams, David Heroux, David McKay, Roy Joseph, John S Zil MD, Nadim Khoury, James Gomez, Joseph Sandoval (old) (Entered: 07/26/1991)

* * * *

Date Filed	#	DOCKET TEXT
11/14/1991	109	ORDER by Honorable Lawrence K. Karlton granting report & recommendation motion REPORT AND RECOMMENDATION [101-1] granting motion for class certification; defts to post the attached notice in all prisons within 5 days of the date of this order; SEE ORDER FOR DETAILS RE CLASS CERTIFICATION (cc: all counsel) (old) (Entered: 11/14/1991)

* * * *

Date Filed	#	DOCKET TEXT
5/11/1992	232	ORDER by Honorable Lawrence K. Karlton ORDERING: preliminary injunction (enforcement order) re heat plans; SEE ORDER FOR DETAILS (cc: all counsel) (old) (Entered: 05/11/1992)
		* * * *
5/25/1993	507	ORDER by Honorable Lawrence K Karlton ADOPTING IN FULL report & recommendation of 5/3/93 [483-1]; Pltf's motion to modify preliminary injunction re protection of class members from excessive heat is GRANTED; Preliminary injunction of 5/11/92 is modified-SEE ORDER FOR DETAILS; and Defts shall inform the court and pltf's counsel of wich record-keeping and reporting requirements they will follow within 10 days of the date of this order (cc: all counsel) (old) (Entered: 05/25/1993)
		* * * *
6/22/1993	518	MINUTES before Magistrate John F Moulds re court trial day 39; exhibits; cross-exam; testimony; C/R: Laura Cerda (old) (Entered: 06/24/1993)
		* * * *

Date Filed	#	DOCKET TEXT
6/6/1994	547	REPORT AND RECOMMENDATION by JFM recommending that (1) the district court appoint a special master to consult with the court re appointment of experts to develop protocol, moniter compliance, report to the court on adequacy of suicide prevention, (2) within 30 days of that order, defts shall develop and use standardized mental health screening forms, (3) within 90 days of that order, defts shall implement a training program to train all medical tech of the signs and symptoms of mental ilness, (4) within 30 days of the order, defts shall develop and implement medication protocols to establish adequate formulary, (5) within 90 days of the order, defts shall develop and implement aplan to use transfer notes and to transfer medical records with transfer of inmates, (6) within 90 days of the order, defts shall develop and implement a formula for mental health care staffing regulations, (7) within 90 days of the order, defts shall implemnet a recruitment program re mental health staff, (8) within 90 days of the order, defts shall fill those positions presently authorized for the provision of mental health care services, (9) within 90 days of

Date Filed	#	DOCKET TEXT
		the order, defts shall implement a system for quality assurance and peer review of mental health care services, (10) within 60 days of the order, defts shall implemnet a protocol to guarantee prompt access to inpatient psychiatric hospitilization for every class member in need of such, (11) within 90 days of the order, defts shall implement a protocol to govern placemnet and retention of the mentally ill, (12) within 90 days of the order, defts shall implement protocols to govern use/non-use of tasers and other measures on class members, (13) within 90 days of the order, defts shall develop a standardized protocol for completion and maintanence of adequate medical records, (14) the prelimianry injunction re heat plans to remain in effect for 3 years, and (15) defts' motion for judgment be denied; Objections due within 20 days of service; Replies due within 10 days thereafter (cc: all counsel) (old) (Entered: 06/06/1994)
		* * * *
07/12/1995	597	ORDER by Honorable Lawrence K. Karlton: The class is decertified as to the Rehabilitation Act claim; plaintiffs' claim under the Rehabilitation Act is hereby dismissed

Date Filed	#	DOCKET TEXT
		with prejudice (cc: all counsel) (old) (Entered: 07/13/1995)
		* * * *
09/13/1995	612	ORDER by Honorable Lawrence K. Karlton GRANTING motion by defendants to strike exhibits A, C-L to declaration of Specter and DENIED as to Exhibit B to the Specter declaration [573-1]; except as modified by this order, the findings & recommendation [547-1] are ADOPTED IN FULL, said recommendations to be implemented by subsequent order of the court; dfts' motion for judgment pursuan tto FRCP 52(c), made at the close of pltfs' case in chief, is DENIED; this matter is REFERRED BACK to the magistrate judge for nomination of a special master; said nomination shall be accomplished within a time period recognizing the urgency of the problems to be remedied and with such consultation with the parties as the magistrate judge deems appropriate; dfts' request for a stay pending appeal is DENIED (cc: all counsel) (old) (Entered: 09/13/1995)
		* * * *

Date Filed	#	DOCKET TEXT
12/11/1995	639	ORDER APPOINTING SPECIAL MASTER by Honorable Lawrence K. Karlton ORDERED that the Findings & recommendations filed 11/16/95 [632-1] are ADOPTED in full and J Michael Keating, Jr is appointed to serve as special master in this case (cc: all counsel) (ndd) (Entered: 12/12/1995)
		* * * *
2/7/1996	659	ORDER by Honorable Lawrence K. Karlton setting timelines regarding special master (See order for mor[e] specific details) (cc: all counsel) (old) Modified on 01/29/1997 (Entered: 02/08/1996)
		* * * *
03/12/1996	671	NOTICE OF FIRST REPORT OF THE SPECIAL MASTER ON THE REMEDIAL PLAN (old) (Entered: 03/15/1996)
		* * * *
04/17/1996	678	SECOND REPORT of the Special Master on Remedial Plans (old) (Entered: 04/19/1996)
		* * * *
5/9/1996	693	ORDER by Honorable Lawrence K. Karlton: all parties to submit briefs re: the impact of section 802(f)(4) on the special masters/mediators and

Date Filed	#	DOCKET TEXT
		their staff; whether this section is app[l]icable if no federal funds available; whether the statute may be applied if it impairs the courts duty to enforce the provisions of the constitution; hearing SET for 2pm on 6/17/96 ; dfts to file and serve brief by fax on pltfs' counsel by 5/24/96; pltfs to file and serve brief by fax on dfts' counsel by 5/31/96; dfts' reply brief DUE 6/7/96 (cc: all counsel) (old) (Entered: 05/09/1996)
		* * * *
7/12/1996	710	ORDER by Honorable Lawrence K. Karlton DIRECTING Mr Keating to resume his duties and the state is ORDERED to continue to compensate him under the court's original order (cc: all counsel) (kdc) (Entered: 07/15/1996)
		* * * *
01/13/1997	785	FIRST INTERIM progress report by movant J Michael Keating Jr (dd) (Entered: 01/14/1997)
		* * * *
01/30/1997	795	ORDER by Honorable Lawrence K. Karlton directing the Special Master to submit for court approval, by 5/15/97, plans, procedures, policies, forms and other applicable documentation concerning aspects

Date Filed	#	DOCKET TEXT
		of dfts' delivery of mental health care services to the pltf class (cc: all counsel) (old) (Entered: 01/30/1997)
		* * * *
06/06/1997	850	SPECIAL MASTER'S REPORT ON PLANS (dd) (Entered: 06/10/1997)
		* * * *
6/27/1997	858	ORDER by Honorable Lawrence K Karlton ORDERING that the 6/6/97 report of the special master on plans [850-1] is accepted by the court; within fifteen days from the date of this order dfts shall make the modifications recommended by the special master in the 6/6/97 report (see order for specific details); as modified, dfts' remedial plans are provisionally approved; the special master shall forthwith commence monitoring dfts' implementation of and compliance with the remedial plans provisionally approved by the court in accordance with this court's 12/11/95 order; the special master shall file compliance reports on a quarterly basis (cc: all counsel) (dd) (Entered: 06/27/1997)
		* * * *
04/21/1998	936	FIRST MONITORING REPORT OF the Special Master J Michael Keating Jr on the dfts' compliance

Date Filed	#	DOCKET TEXT
		with provisionally approved plans, policies and protocols (ndd) (Entered: 04/22/1998)
		* * * *
05/21/1998	945	STIPULATION AND ORDER by Honorable Lawrence K. Karlton Accordingly, the parties hereby stipulate as follows: In order to start implementation of the overall plans, CDC may proceed to obtain licensure of 84 add'l mental health intermediate inpatient care beds at CMF and 64 new mental health intermediate inpatient care beds at SVSP; DMH will provide clinical services for these programs; those inmates housed in the DMH day treatment program at CMF at the time that the conversion is to take place will remain in the new intermediate inpatient care beds until such time as DMH determines that their mental health needs can be met in a different program (cc: all counsel) (old) (Entered: 05/21/1998)
		* * * *
06/16/1998	948	ORDER by Honorable Lawrence K. Karlton ORDERING that within 60 days from the date of this order, dfts shall submit to the special master and file with the court evidence demonstrating that they

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		have improved both the quality and quantity of contracted psychiatric services and/or that they have implemented their recruitment program sufficiently to fill vacancies in presently authorized clinical positions; within 60 days from the date of this order, dfts shall submit to the special master and file with the court a written statement of the CA Dept of Corrections' department-wide policy on the relationship between the use of force against seriously mentally ill inmates and general departmental policies on the use of 37mm weapons, OC gas and cell extractions the reporting schedule contained in the 6/27/97 order is modified as follows: "a) on or before 9/1/98, the special master shall conduct and report on a survey of the extent to which the inmate population incarcerated prior to mid 1994 has received a mental health screening; b) on or before 11/15/98, the special master shall file recommendations for staffing ratios; c) On or before 12/31/98, the special master shall file recommendations on involuntary medications, on any proposed changes in the delivery of mental health care services in administrative segregation, and on the use of a computerized identifier

Date Filed	#	DOCKET TEXT
		code for seriously mentally disordered inmates;" within 30 days from the date of this order, the special master shall file with the court a recommended schedule for implementation of dfts' quality assurance plans; the deadlines set in this order will be strictly enforced and no extensions of time will be granted except on a showing of exceptional cause (cc: all counsel) (ndd) (Entered: 06/16/1998)
		* * * *
8/12/1998	964	ORDER by Honorable Lawrence K. Karlton ORDERING that the special master's recommendation is adopted in full; not later than 12/31/98, dfts shall implement fully a quality assurance and peer review process in their mental health delivery system; the special master and his staff shall commence a first evaluation of said process in 1/99 (cc: all counsel) (ndd) (Entered: 08/12/1998)
		* * * *
8/25/1998	968	ORDER by Honorable Lawrence K. Karlton ORDERING that within 30 days from the date of this order, the Special Master shall report to the court on the adequacy of dfts' staffing efforts and their policy

Date Filed	#	DOCKET TEXT
		concerning the use of force on seriously mentally disordered inmates, as evidenced by the material filed with the court in response to the 6/16/98 order (cc: all counsel) (ndd) (Entered: 08/25/1998)
		* * * *
09/22/1998	974	REPORT OF THE SPECIAL MASTER on staffing and the use of force submitted by Special Master J Michael Keating Jr (old) (Entered: 09/23/1998)
		* * * *
10/8/1998	978	ORDER by Honorable Lawrence K. Karlton ORDERING that within 30 days from the effective date of this order, dfts shall file and serve a response to pls' objections; in their response, dfts shall set forth in detail what steps were taken in response to the alternatives proposed in the 3/17/98 Dept of Finance rejection of the Dept of Corrections' bonus proposal and the reasons for the decision made in connection therewith, this matter [975-1] is SET for 9:30 12/9/98 (cc: all counsel) (ndd) (Entered: 10/08/1998)
		* * * *

Date Filed	#	DOCKET TEXT
10/23/1998	981	SECOND MONITORING REPORT OF THE SPECIAL MASTER on dfts' compliance with provisionally approved plans, policies and protocols (kdc) (Entered: 10/26/1998)
		* * * *
11/19/1998	991	ORDER by Honorable Lawrence K. Karlton ORDERING that within 30 days from the date of this order, dfts shall submit to the special master detailed plans for addressing effectively the causes of service delivery deficiencies at CA Rehabilitation Center, Mule Creek State Prison, Salinas Valley State Prison and Wasco State Prison, with attention to administrative leadership, staffing, custody, and mental health staff relations, training, records compilation and maintenance, medication management, and management information systems; the plan shall target the delivery within 90 days of the full complement of mental health services required in the Program Guides to all inmates on the mental health caseload; within 30 days from the date of this order, dfts shall submit to the special master plans to address the following problems identified by the special master: inappropriate use of the DVI infirmary for mental health

Date Filed	#	DOCKET TEXT
		crisis bed patients; coordination of mental health services for CA Rehabilitation Center inmates in administrative segregation at CMF and CA CWF, and heat problems at CA State Prison-Solano (cc: all counsel) (ndd) (Entered: 11/19/1998)
		* * * *
11/20/1998	994	SPECIAL MASTER'S RECOMMENDATIONS FOR STAFFING RATIOS (kdc) (Entered: 11/23/1998)
11/23/1998	995	SECOND MONITORING REPORT OF THE SPECIAL MASTER on the Dfts' complaince with provisionally approved plans, policies and protocols (old) (Entered: 11/24/1998)
		* * * *
12/03/1998	1000	SECOND MONITORING REPORT of the Special Master on the dfts' compliance with provisionally approved plans, policies and protocols (kdc) (Entered: 12/04/1998)
		* * * *
12/9/1998	1003	MINUTES of 12/9/98 before Honorable Lawrence K. Karlton; hearing on special master; recommendations re staffing rates; both sides to report to court within 30 days; order to be prepared by dfts (as) (Entered: 12/10/1998)
		* * * *

Date Filed	#	DOCKET TEXT
1/5/1999	1008	Special Master's Recommendations on Administrative Segregation, Involuntary Medications and Identifier Coding (ndd) (Entered: 01/06/1999)
		* * * *
1/19/1999	1010	ORDER by Honorable Lawrence K. Karlton ORDERING that plts' objections [976-1] are overruled and the Report of the Special Master [974-1] is ADOPTED by the court; the dfts are to report to the Special Master 90 days from the date of this order on the progress they have made in filling vacant mental health staff positions; the Special Master shall report to the Court within 30 days after receipt of the dfts' report regarding the success of the dfts in filling vacant mental health staff positions; either party may file objections with the court within 30 days after service of the report (See Order for details) (cc: all counsel) (ndd) (Entered: 01/19/1999)
		* * * *
4/9/1999	1021	STIPULATION AND ORDER by Honorable Lawrence K. Karlton ORDERED that the dfts will provide plts and the Special Master with specific information regarding their plans for increased staffing

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		and the provision of mental health care to inmates in administrative segregation on or before 4/19/99; if such plans will not be forthcoming by that date, dfts will so notify the plts' counsel and the Special Master; the Special Master will then issu[e] a single report by 4/30/99, addressing both staffing and administrative segregation; the parties will have 30 days after service of the report to file objections with the court (cc: all counsel) (ndd) (Entered: 04/09/1999)
		* * * *
05/19/1999	1032	SPECIAL MASTER'S REPORT on staffing vacancies (kdc) (Entered: 05/20/1999)
05/19/1999	1033	SUPPLEMENTAL [1033-1] RECOMMENDATIONS OF THE SPECIAL MASTER on staffing ratios and administrative segregation (mll) Modified on 07/14/1999 (Entered: 07/14/1999)
		* * * *
05/26/1999	1036	THIRD MONITORING REPORT of the special master on the dfts compliance with provisionally approved plans, policies and protocols (mll) (Entered: 05/27/1999)

Date Filed	#	DOCKET TEXT
05/26/1999	1037	EXHIBITS regarding [1036-1] (mll) (Entered: 05/27/1999)
		* * * *
07/23/1999	1054	ORDER by Honorable Lawrence K. Karlton ORDERING that the stipulation and proposed order amending the pltf class and application of remedy is GRANTED; it is ORDERED that all matters stipulated by the parties are so ordered nunc pro tunc to 12/24/98 (cc: all counsel) (old) (Entered: 07/23/1999)
07/26/1999	1055	ORDER by Honorable Lawrence K. Karlton ORDERING that within 90 days from the date of this order dfts shall reduce the vacancy rate among psychiatrists to 25% or les[]s and among psych social workers to 10% or less, while keeping vacancy rates among other categories of mental health staff at present or comparable rates; within 90 days from the date of this order dfts shall reduce the employment of multiple, short-term contract psychiatrists, as defined by the special master and this order, to fill vacancies from the current 40% to 25% or less of contract services provided, without reducing overall contract services unless justified in specific instances by decreasing vacancies; within 90 days dfts shall develop and submit

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		to the special master a plan for the retention of psychiatrists in CDC, addressing such issues as the payment structure that penalizes clinical administrators , opportunities for career and professional development, flexibility and enhancements for remote assignments, the development of incentives, monetary and/or otherwise, for longevity, etc; on or before 12/31/99 the special master shall file further recommendations addressing the staffing ratio of psychiatrists to inmates in the 3CMS program; on or before 12/31/99, dfts shall adopt and implement the following staffing ratio for administrative segregation; within 90 days from the date of this order, dfts shall develop and implement a plan to train mental health staff, staff assistants and hearing officers involved in the new policy on mental health input into the adjudication of disciplinary infractions, the 115 process; within 90 days from the date of this order, dfts shall develop and implement a system-wide date collection process for capturing information on mental health transfers at the institutional level; on or before 12/31/99, dfts shall develop and implement a plan for expediting the transfers

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		of seriously mentally disordered inmates to programs with the level of care to which they have been referred; within 90 days, dfts shall develop a system in each institution for identifying and recording self-injurious episodes, including forms, logs and other documents necessary to support such a recording system; within 90 days dfts shall develop a process for tracking self-injurious inmates discharged from an infirmary or MHCB unit to make sure that indicated clinical follow up occurs as prescribed; within 90 days dfts shall develop and implement a system-wide method for tracking, recording and aggregating institutional data on staff members' completion of mental health training courses required in the plans provisionally approved by the court in June 1997; Said system shall list all staff in an institution with an indication of whether each individual has, or has not, attended required courses (See order for details) (cc: all counsel) (ndd) (Entered: 07/26/1999)

* * * *

Date Filed	#	DOCKET TEXT
11/15/1999	1082	SPECIAL MASTER'S RECOMMENDATIONS on dfts transition plan for the California Medical Facility (mll) (Entered: 11/16/1999)
		* * * *
12/07/1999	1093	FOURTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DFTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS POLICIES AND PROTOCOLS (old) (Entered: 12/08/1999)
12/07/1999	1094	EXHIBITS by the Special Master of the Fourth monitoring report (old) (Entered: 12/08/1999)
		* * * *
12/09/1999	1097	ORDER by Honorable Lawrence K. Karlton ORDERING that within 15 days from the date of this order the Special Master shall file recommendations concerning dfts' request for extension of time [1073-1] and pltf's requests for orders directing dfts to increase pay for psychiatrists and directing the Special Master to develop a retention plan (cc: all counsel) (old) (Entered: 12/09/1999)
		* * * *
12/21/1999	1101	ORDER by Honorable Lawrence K. Karlton ORDERING that within 21 days from the date of this order dfts shall provide to the special master

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		specific information on how they will meet the need for the 9.66 custody positions they have identified as necessary for the 1st stage of the transition process; AND within 7 days thereafter the special master shall report to the court whether information provided is satisfactory and whether the transaction plan is ready for consideration of approval by the Court; (cc: all counsel) (old) (Entered: 12/21/1999)
12/27/1999	1102	LETTER to court from counsel J Michael Keating Jr. enclosing a copy of the special master's recommendations (old) (Entered: 12/27/1999)
		* * * *
1/13/2000	1111	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts' 10/26/99 request for an extension of time to comply with directives 1, 2 and 8 of this court's 7/26/99 order [1073-1] is GRANTED; dfts are granted an additional period of 90 days to comply with directives 1 and 2 of the 7/26/99 order [1055-1]; dfts are granted an additional period of 180 days to comply with directive 8 of 7/26/99 order; within 30 days from the date of this order; dfts shall increase the annual compensation of all classes of full-time

Date Filed	#	DOCKET TEXT
		psychiatrists employed by the CDC by no less than $20,000; within 30 days from the date of this order, dfts shall submit to the special master a list of psychiatrists employed by the CDC who have left employment within the past 24 months, with information on their length of service and the reasons for their departure; within 45 days thereafter the special master shall report to the court on the scope of the problem with retention of CDC psychiatrists and the adequacy of dfts' retention plan (cc: all counsel) (ndd) (Entered: 01/13/2000)
		* * * *
02/10/2000	1132	ORDER by Honorable Lawrence K. Karlton ORDERING that Clerk is directed to file the proposed transition plan lodged with the court on 11/9/99 [1079-1]; within 20 days from the date of this order, dfts shall provide the special master a list of all inmates on the mental health caseload in CMF; within 30 days from the date of this order, dfts shall submit to the special master a description of how their plan for delivering services to the Clark population will mesh with the transition plan; the special master shall file quarterly reports on the

Date Filed	#	DOCKET TEXT
		progress of implementation of the transition plan, with the first quarterly report covering the period from the entry of this order through 5/31/00 (See order for details) (cc: all counsel) (ndd) (Entered: 02/10/2000)
		* * * *
02/22/2000	1135	ORDER by Honorable Lawrence K. Karlton ORDERING that the Report [1130-1] is ordered filed and the report is accepted as representing the status of dfts' mental health programs at the CMF (cc: all counsel) (ndd) (Entered: 02/22/2000)
		* * * *
03/31/2000	1143	NOTICE of filing of special master's interim report on DMH inpatient care (ch) (Entered: 04/03/2000)
04/14/2000	1144	5TH MONITORING REPORT of the special master on the dft's compliance with provisionally approved plans, policies and protocols (old) (Entered: 04/17/2000)
		* * * *
04/24/2000	1149	SPECIAL MASTER'S RECOMMENDATIONS on the development of a retention plan for psychiatrists (mll) (Entered: 04/25/2000)
		* * * *

Date Filed	#	DOCKET TEXT
4/27/2000	1155	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts' 2/14/00 request for an extension of time [1134-1] is GRANTED nunc pro tunc, the information submitted by dfts to the special master pursuant to paragraph 5 of this court's 1/13/00 order is deemed timely submitted; plts' 11/15/99 request for an order requiring the special master develop a plan for retention of CDC psychiatrists is DENIED; dfts shall submit to the special master on a quarterly basis a report on the departure of psychiatrists from CDC employment; dfts' 12/30/99 request for an extension of time to comply with Directives 6 and 9 of the court's 7/26/99 order [1103-1] is GRANTED in part as follows: dfts shall comply with Directive 6 of the 7/26/99 order on or before 5/2/00; dfts shall comply with Directive 9 of the 7/26/99 order [1055-1] on or before 6/30/00; dfts' 1/24/00 request for an extension of time to comply with Directive 1 of the court's 7/26/99 order [1116-1] is GRANTED; dfts shall comply with Directive of the court's 7/26/99 order on or before 5/26/00; on or before 6/16/00, the special master shall report to the court on the status of vacancy rates among CDC

Date Filed	#	DOCKET TEXT
		psychiatrists and psychiatric social workers; on or before 9/1/00, the special master shall file further recommendations addressing the staffing ratio of psychiatrist to inmates in the 3CMS program (cc: all counsel) (ndd) (Entered: 04/27/2000)
		* * * *
06/12/2000	1172	SPECIAL MASTER'S INTERIM REPORT AND RECOMMENDATION ON DMH INPATIENT CARE by movant J Michael Keating (old) (Entered: 06/12/2000)
		* * * *
8/28/2000	1198	ORDER by Honorable Lawrence K. Karlton ORDERING: Defendants' 5/26/00 request for a third extension of time to comply with Directive 1 of the court's 7/26/99 order is granted; defendants shall comply with Directive 1 of the court's 7/26/99 order by 12/31/00; on or before 12/15/00 the special master shall report to the court on the adequacy of defendants compliance with Directive 1 and shall make such recommendations to ensure compliance as appear needed that time; defendant shall forthwith restore the differential in recruitment and retention bonuses for remote CDC facilities; within 15

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		days from the date of this order, defendants shall report to the special master their plan to effect restoration of said bonuses and within 15 days thereafter the special master shall report to the court on the adequacy of defendants plan (old) (Entered: 08/28/2000)
		* * * *
9/14/2000	1201	ORDER by Honorable Lawrence K. Karlton ORDERING that on or before 11/30/00 dfts shall develop and provide to the special master and to pltfs a set of guidelines for the timeliness of transfers of inmates to necessary levels of care; on or before 12/31/00 the parties and special master shall meet and confer and shall finalize said guidelines; dfts shall forthwith develop sufficient level IV enhanced outpatient beds to meet the system-wide need; within thirty days from the date of this order dfts shall promulgate a plan for staffing and placement of the beds; within sixty days from the date of this order dfts shall complete the review described in paragraph 3 of the special master's 8/28/00 recommendations and shall submit to the special master their recommendations; on or before 12/31/00 dfts shall complete negoti-

Date Filed	#	DOCKET TEXT
		ations on the memorandum of understanding between the DMH and CDC; dfts shall comply fully with the recommendations; on or before 12/31/00 dfts shall develop such plans for improvement of the transfer process as appear necessary (cc: all counsel) (hk) (Entered: 09/14/2000)
		* * * *
10/10/2000	1213	SIXTH MONITORING REPORT OF THE SPECIAL MASTER on dfts' compliance with provisionally approved plans, policies and protocols (kdc) (Entered: 10/11/2000)
		* * * *
12/14/2000	1224	SECOND QUARTERLY REPORT on implementation of the Gates-Coleman transition plan by J Michael Keating Jr (ndd) (Entered: 12/14/2000)
		* * * *
12/20/2000	1227	SPECIAL MASTER'S REPORT AND RECOMMENDATIONS ON PSYCHIATRIST AND PSYCHIATRIC SOCIAL WORKER VACANCIES by movant J Michael Keating Jr (old) (Entered: 12/21/2000)
		* * * *

Date Filed	#	DOCKET TEXT
12/22/2000	1229	ORDER by Honorable Lawrence K. Karlton ORDERING that the observations and recommendations found at pages 5 and 6 of the Suicide Report appended to the Sixth Monitoring Report [1213-1] are adopted, within 60 days the special master shall report to the court on (1) whether dfts have in place mechanism either for internal discipline of CDC staff whose unethical, negligent and/or criminal misconduct to other entities; (2) the adequacy of any such mechanisms that presently exist; and (3) whether additional discipline or reporting mechanisms should be developed; within 30 days from the date of this order the special master shall make specific recommenddations to the court concerning access for class members to mental health crisis beds; dfts' 10/2/00 request to withdraw objections [1210-1] is GRANTED, dfts' 9/19/00 objections to the assessor's third compliance report [1203-1] shall be placed in the court file and disregarded (cc: all counsel) (ndd) (Entered: 12/22/2000)

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Date Filed	#	DOCKET TEXT
1/9/2001	1235	SPECIAL MASTER'S recommendations for transfer timelines (old) (Entered: 01/10/2001)
		* * * *
01/22/2001	1240	SPECIAL MASTER'S RECOMMENDATIONS ON ACCESS TO MENTAL HEALTH CRISIS BEDS by movant J Michael Keating Jr (old) (Entered: 01/23/2001)
		* * * *
02/23/2001	1252	SPECIAL MASTER'S REPORT on dfts' mechanisms for disciplining staff whose negligence or misconduct contributes to an inmate suicide (old) (Entered: 02/26/2001)
		* * * *
4/4/2001	1262	ORDER by Honorable Lawrence K. Karlton ORDERING that the 12/20/00 report and recommendations of the special master concerning staffing vacancies [1227-1] are adopted in full; dfts shall explore honestly and fully the feasibility of each alternative for reducing staffing vacancies set forth in the 12/20/00 report and recommendations and shall diligently pursue each feasible alternative; the special master shall report to the court on a quarterly basis on progress in the development of these alternative

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		efforts and their impact on staff vacancy rates; the special master's 1/9/01 recommendations regarding transfer timelines [1235-1] are adopted in full and shall be implemented forthwith; on or before 5/15/01, the special master shall report to the court on the adequacy of the number of available beds at each level of care and the scope, if any, of the problem of delay in transfer that may be caused by insufficient bed availability; and on or before 5/15/01, the special master shall submit revised recommendations on access to mental health crisis beds (cc: all counsel) (ndd) (Entered: 04/04/2001)
		* * * *
04/17/2001	1265	Special Master's Report on Defendant's Compliance With Recommendations for Access to DMH Inpatient Care (ds) (Entered: 04/18/2001)
		* * * *
05/23/2001	1272	SPECIAL MASTER'S REPORT by movant J Michael Keating Jr regarding program bed space and revised recommendations on access to mental health crisis beds (lm) (Entered: 05/24/2001)
		* * * *

Date Filed	#	DOCKET TEXT
6/27/2001	1278	ORDER by Honorable Lawrence K. Karlton ORDERING dfts to identify and track "psych and return" transfers from the Dept of Mental Acute care program at CMF to DVI, CTF, CFC, CSATF, SVSP, and CSP/LAC and transfer of enhanced outpatient program inmates to administrative segregation units in SVSP and CSP/LAC in a log that will facilitate follow-up treatment; dfts shall report every 6 months on the progress of all outstanding construction projects for the enhancement of programming and office space; within 10 days of completion of the budget process relative to program staffing issues discussed in the special master's report filed 5/23/01, dfts shall file and serve a report to the court on the outcome of said process; on or before 7/6/01, dfts shall submit to the parties and the special master the Dept of Mental Health inpatient bed usage study and needs assessment; within 10 days from the date of this order, dfts shall inform court of the execution of the contract for services between CDC and the Dept of Mental Health; dfts shall work with DVI, CTF, CCI and San Quentin to develop and implement within 60 days an expedited process to

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		transfer inmates to a mental health crisis bed level of care to facilities with the required level of care within 24 hours (cc: all counsel) (bd) Modified on 06/28/2001 (Entered: 06/27/2001)
		* * * *
09/05/2001	1297	SPECIAL MASTER'S SUPPLEMENTAL REPORT on dfts' mechanism for disciplining staff whose negligence or misconduct contributes to an inmate suicide [1252-1] (old) (Entered: 09/06/2001)
		* * * *
09/25/2001	1303	EIGHTH INTERIM MONITORING REPORT of the special master on the defendant's compliance with provisionally approved plans, policies and protocols (lm) (Entered: 09/26/2001)
09/26/2001	1304	SPECIAL MASTER'S First Qtrly Report on dfts' efforts to reduce staffing vacancies by defendants John S Zil MD, Nadim Khoury, James Gomez, and Joseph Sandoval (ak) (Entered: 09/27/2001)
		* * * *
10/1/2001	1306	ORDER by Honorable Lawrence K. Karlton ORDERING within 30 days from the date of this order defendants shall implement the Suicide

Date Filed	#	DOCKET TEXT
		Reporting and Review Policy appended as Exhibit B to the special master's 09/04/01 supplemental report [1296-1]; and within 45 days from the date of this order the special master shall report to the court on the adequacy of defendant's response to paragraph 6 of this court's 06/27/01 order [1278-1] and whether the system described in said response has been implemented (cc: all counsel) (mdp) (Entered: 10/01/2001)
		* * * *
10/26/2001	1309	ORDER by Honorable Lawrence K. Karlton ORDERING that within ninety days from the date of this order dfts shall meet the staffing ratio of one case manager for every nine inhanced outpatient inmates in hub administrative segregation units and dfts shall maintain said staffing ratio thereafter; within thirty days from the date of this order Health Care Services Division shall submit to the special master a plan for bringing Cal Substance Abuse Treatment Facility into compliance with the plans; within thirty days from the date of this order Cal State Prison-Los Angeles County shall develop and implement procedures for the identifica-

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		tion of inmates arriving at the facility with a valid Keyhea order; No EOP inmate shall be transferred to the CSP/LAC hub administrative segregation unit until the facility is able to provide psych tech rounds seven days a week; within 120 days from the date of this order the special master shall report to the court on the adequacy of dfts' compliance with the requirements of this order (cc: all counsel) (hk) (Entered: 10/26/2001)
		* * * *
11/16/2001	1315	NOTICE of Special Masters Report on dfts expedited process for transfers to a mental health crisis bed by J Michael Keating Jr (mdk) (Entered: 11/19/2001)
		* * * *
11/27/2001	1317	EIGHTH MONITORING REPORT OF THE SPECIAL MASTER on dfts' compliance w/ provisionally approved plans, policies and protocols (old) (Entered: 11/28/2001)
11/27/2001	1318	EXHIBITS regarding the Eighth Monitoring Report of the Special Master [1317-1] (old) (Entered: 11/28/2001)
		* * * *

Date Filed	#	DOCKET TEXT
12/20/2001	1323	ORDER by Honorable Lawrence K. Karlton ORDERING that not later than 1/31/02, dfts shall complete their inpatient bed needs study and submit to the special master a plan to meet those needs, within 30 days from the date of this order, dfts shall submit to the special master a plan for meeting the system's existing need for beds at the psychiatric service unit, mental health crisis bed, and both administrative segregation and general population enhanced outpatient program levels; within 30 days from the date of this order, dfts shall submit to the special master a detailed list of measures already completed or projected to meet programming space needs in regional administrative segregation units; within 30 days thereafter the special master shall report to the court on the adequacy of said measures; within 30 days from the date of this order, dfts shall (a) complete the review and revision of their policies and procedures for conducting assessment of mental health service delivery system inmates charged with disciplinary infractions and scheduled for a disciplinary hearing (b) develop a plan for training clinicians and

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		hearing officers in the revised policies and procedures (c) submit the revised policies and procedures and the training plan to the special master; within 30 days thereafter, the special master shall report to the court on the adequacy of said policies, procedures, and training plan; within 60 days from the date of this order, dfts shall submit to the special master a plan for addressing long-term programming spacing needs in the Locked Observation Unit at California Men's Colony (see order for details) [1317-1] (cc: all counsel) (ndd) (Entered: 12/20/2001)
		* * * *
2/26/2002	1351	SPECIAL MASTER'S SECOND QUARTERLY REPORT on dfts' efforts to reduce staffing vacancies (kdc) (Entered: 02/26/2002)
		* * * *
4/9/2002	1367	ORDER by Honorable Lawrence K. Karlton ORDERING that the transition process ratified in the 2/10/00 order [1132-1] is terminated; paragraphs 2A, 2B, 2C, 2D, 2E, 2F, 2G, 2H, 2I, 2J, 2L, 2N, 2Q, 2R, 2T, 2U and 2V of the 2/10/00 order are dismissed; the recommendation with respect to para-

graph 2K of the 2/10/00 order shall henceforth be governed by the provisions of the court's 3/4/02 order; on or before 4/30/02, dfts shall complete their study of the adequacy of treatment provided to Intensive Outpatient Care inmates transferred from CMF to other CDC institutions and submit to the special master any resulting proposal for new or modified programs; on or before 5/31/02, the special master shall report to the court on the adequacy of the study referred to in paragraph 4 of this order and any resulting proposals; dfts shall implement fully and immediately the psych and return policies and procedures as revised in July 2001; the special master shall assess the effectiveness of the policy, particularly in assuring clinician-to-clinician contacts regarding seriously mentally disordered inmates returned to CDC institutions from CMF/Dept of Mental Health inpatient programs, through 9/1/02 and shall, by that date, report to the court on the adequacy of the implemented policies and procedures together with any needed recommendations for changes in the policy; if dfts elect to house Mental Health Services Delivery

Date Filed	#	DOCKET TEXT
		System inmates in the Willis Unit at CMF, they shall meet applicable staffing requirements for administrative segregation units 30 days in advance of any such placements and submit a report to the special master on the results of their consideration of restricting the housing of MHSDS inmates to a particular and special area of the Willis Unit; within 30 days from the date of this order dfts shall submit to the special master a long-term plan for providing a Mental Health Crisis Bed level of care for seriously mentally disordered inmates in CMF (cc: all counsel) (ndd) Modified on 04/09/2002 (Entered: 04/09/2002)
		* * * *
4/16/2002	1369	SPECIAL MASTER'S REPORT on the dfts' Inpatient Bed Needs Study by J Michael Keating Jr (ndd) (Entered: 04/17/2002)
		* * * *
04/25/2002	1372	ORDER by Honorable Lawrence K. Karlton ORDERING special master's recommendations [1371-1] are ADOPTED; see order for more details (cc: all counsel) (bd) (Entered: 04/25/2002)

Date Filed	#	DOCKET TEXT
04/25/2002	1373	NINTH MONITORING REPORT OF THE SPECIAL MASTER by movant J Michael Keating Jr regarding defendants' compliance with provisionally approved plans, policies and protocols (sk) (Entered: 04/26/2002)
04/25/2002	1374	EXHIBITS by movant J Michael Keating Jr regarding ninth monitoring report [1373-1] (sk) (Entered: 04/26/2002)
5/7/2002	1375	ORDER by Honorable Lawrence K. Karlton ORDERING the special master's recommendations [1369-1] ADOPTED in full; On or before 5/3/02 dfts shall meet with the special master's experts to review and, where appropriate, revise the perceived inaccuracies and questionable assumptions catalogued in the special master's 4/16/02 report; On or before 7/31/02 dfts shall recalculate their projected future need for program beds and submit to the special master a plan for the development of whatever programming needs are identified in the revamped study; On or before 7/31/02 dfts and their consultants shall carefully review with the special master's experts the feasibility and benefit of a comprehensive assessment of the CDCs' actual

Date Filed	#	DOCKET TEXT
		need for Dept of Mental Health inpatient beds and if said review is positive develop and submit to the special master a plan for its execution; If said review is negative dfts need to submit to the special master by 7/31/02 written justification for modification of that portion of this court's 2/10/00 order requiring said study; On or before 8/30/02 the special master shall file a further report to the court on the status of the matters described in paragraphs 2 and 3 of this order (cc: all counsel) (nac) (Entered: 05/07/2002)
		* * * *
05/29/2002	1381	SPECIAL MASTER'S REPORT ON DEFENDANTS' INTENSIVE OUTPATIENT CARE (IOC) STUDY by movant J Michael Keating Jr (old) (Entered: 05/30/2002)
		* * * *
06/13/2002	1383	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts shall maintain the vacancy rate among psychiatrists and case managers at a maximum of 10%, including contracted services and dfts shall keep the special master informed of the results of final collective bargaining agreements with all categories of mental health and

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		medical staff that impact the delivery of mental health services, with a focus on any changes in existing terms of collective bargaining agreements that may enhance or impede future recruitments in each category [1351-1] (cc: all counsel) (ndd) (Entered: 06/13/2002)
6/13/2002	1384	ORDER by Honorable Lawrence K. Karlton ORDERING that within 60 days from the date of this order, the Health Care Services Division of CDC shall develop a plan identifying what steps the CDC will take to ensure compliance in the following seven institutions: CIM, CSATF, CSp/Corcoran, CSP/LA, CSP/Solano, San Quentin, and SVSP; within 60 days from the date of this order dfts shall develop a plan for eliminating institutional problems with the delivery and management of medication; commencing not later than 30 days from the date of this order, dfts shall provide the special master with monthly statistical data on allocated and vacant medical technical assistant positions in each CDC facility; within 60 days from the date of this order, dfts shall develop a plan to speed the implementation of the quality assurance

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		process within each CDC facility; within 60 days from the date of this order, dfts shall develop a plan to provide sufficient psych techs to conduct rounds 7 days a week in administrative segregation at Calipatria State Prison, CA Correctional Institution, Central CA Women's Facilty, CIM, CSATF, CSP/Corcoran, CSP/LA, CSP/Solano, CTF, DVI, FSP, Ironwood State Prison, Sierra Conservation Center, SQ and SVSP; within 60 days from the date of this order, dfts shall ensure that daily psych techs rounds are actually provided the administrative segregation units of the three hub units to which Enhanced Outpatient Program inmates are being transferred from elsewhere, including CSP/Corcoran, SQ and SVSP [1373-1] (see order for details) (cc: all counsel) (ndd) (Entered: 06/13/2002)
		* * * *
07/10/2002	1392	SPECIAL MASTER'S THIRD QUARTERLY REPORT by movant J Michael Keating Jr regarding dfts' efforts to reduce staffing vacancies (old) (Entered: 07/11/2002)
		* * * *

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7/26/2002	1398	ORDER by Honorable Lawrence K. Karlton ORDERING that within 10 days from the date of this order, the parties, including representatives from the Dept of Finance, shall meet with the special master to identify lal existing mental health staff positions required in pending orders in this case that need to be incorporated in a blanket exemption to the statewide hiring freeze; within 40 days from the date of this order, dfts shall process, approve and finalize a blanket exemption for all those mental health staff positions identified in the meeting described in paragraph 1 of this order; the exemption shall apply both to identified positions that are currently vacant and identified positions that may become vacant in the future during the life of the hiring freeze; this order applies only to currently allocated mental health staff positions and nothing in this order should be construed to circumvent the normal budgetary processes of executive and legislative approval for the lalocation of new or additional positions; dfts shall continue to use contracted services to fill all allocated but vacant positions identified in the meeting described in paragraph 1 of

Date Filed	#	DOCKET TEXT
		this order [1392-1] (cc: all counsel) (ndd) (Entered: 07/26/2002)
		* * * *
9/5/2002	1410	SPECIAL MASTER'S FOLLOW-UP REPORT on the dfts' inpatient bed needs study and plan for development of programming needs by movant J Michael Keating Jr (old) (Entered: 09/06/2002)
		* * * *
09/26/2002	1424	SPECIAL MASTER'S REPORT on psych and return procedures for inmates discharged from the Department of Mental Health's Acute Inpatient Program at the California Medical Facility (sk) (Entered: 09/27/2002)
		* * * *
10/8/2002	1431	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts shall forthwith submit to the special master copies of relevant portions of the fiscal year 2002-2003 pending budget and as they develope and are approved by CDC and the Dept of Finance, relevant portions of future budget requests that reflect proposals for mental health services delivery system (MHSDS) staffing and construction based on the beds needs study; within 90 days from

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		the date of this order, dfts shall submit to the special master a clinical rationale for elimination of the day treatment program at CMF and a plan for providing treatment programming comparable to that currently provided in the intermediate care and day treatment components at CMF; within 60 days from the date of this order, dfts shall submit to the special master a plan to provide MHSDS inmates clinically referred to a mental health crisis bed (MHCB) level of care with both immediate and long-term access to treatment appropriate to that level of care; within 90 days from the date of thsi order dfts shall submit to the special master a plan for the delivery of MHCB level of care to inmates in CA Men's Colony and CMF; within 60 days from the date of this order, dfts shall submit to the special master plan to provide MHSDS inmates clinically referred to an enhanced outpatient level of care, who must be housed in a security housing unit, with both immediate and long-term access to treatment appropriate to that level of care [1410-1] (cc: all counsel) (ndd) (Entered: 10/08/2002)

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Date Filed	#	DOCKET TEXT
10/10/2002	1440	STIPULATION AND ORDER by Honorable Lawrence K. Karlton ORDERED that dfts shall not house mentally ill class members in the new SATF administrative segregation unit or any of the other 9 new administrative segregation units scheduled to open in the near future unless and until the procedures below have been followed and court approved has been obtained for such placements; dfts shall not operate any such program for housing mentally ill inmates in the new administrative segregation unit unless and until there has been review and approval of the proposed program by the special master and the district court and until the special master has inspected the proposed program location to ensure that the staffing and other resources or modifications required by the plan are in place and so certified to the court (see Order for details) (cc: all counsel) (ndd) (Entered: 10/10/2002)
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10/23/2002	1446	TENTH MONITORING REPORT of the Special Master, J Michael Keating Jr, on the dfts' compliance with provisionally approved plan,

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		policies and protocols (daw) (Entered: 10/24/2002)
10/23/2002	1447	EXHIBITS regarding Tenth Monitoring Report of the Special Master, J Michael Keating Jr, on dfts' compliance with provisionally approved plans, policies and protocols [1446-1] (daw) (Entered: 10/24/2002)
		* * * *
12/9/2002	1478	ORDER by Honorable Lawrence K. Karlton ORDERING that within 60 days from teh dte of this order, the Parole and Community Services Division and the Health Care Services Division (HCSD) of the CDC shall develop and implement procedures for the use within each CDC institution of a common and shared list of Mental Health Services Delivery systems inmates eligible for parole and the documentation of all contacts between Transitional Case Management Program social workers and paroling inmates in the paroling inames' Unit Health Records; dft shall forthwith begin implementation of the Mental Health Tracking System in CMF, Ironwood State Prison, and CA State Prison at San Quentin [1446-1] (cc: all counsel) (ndd) (Entered: 12/09/2002)

Date Filed	#	DOCKET TEXT
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06/10/2003	1519	ELEVENTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS, POLICIES AND PROTOCOLS by movant J Michael Keating Jr (sk) (Entered: 06/11/2003)
06/10/2003	1520	EXHIBITS by movant J Michael Keating Jr regarding the Eleventh Monitoring Report [1519-1] (sk) (Entered: 06/11/2003)
		* * * *
7/25/2003	1536	ORDER by Honorable Lawrence K. Karlton ORDERING that 1) dfts shall immediately apply the budgeted $1,000 recruitment and retention bonus for MTA to all MTA posiitons at SVSP and CTF; 2) on or before 11/1/03, dfts shall fill 32 beds in the DMH-run intermediate inpatient psychiatric program at SVSP; 3) on or before 2/1/04, dfts shall bring the DMH-run intermediate inpatient psychiatric program at SVSP to 90% of capacity; 4) on or before 8/1/03, dfts shall finalize and initiate implementation of their new medication management policy; 5) dfts' new medication policy shall include a provision that requires

evening distribution, ie no earlier than 8:00pm, of HS medications, and a supervisory psychiatric oversight or peer review structure that is not so burdensome it precludes or unnecessarily discourages the prescription of HS medications when clinically appropriate; 6) dfts shall begin forthwith the process for the referral and transfer to ASH of those 19 inmates currently housed in the DTP/ICF program who have been identified as eligible for treatment at ASH; 7) on or before 8/30/03, dfts shall assess the inmates remaining in the DTP/ICP to determine the level of treatment they will receive and where they will receive it and shall provide said assessment to the special master; 8) on or before 9/30/03, the special master's psychiatric experts shall review the assessment described in paragraph 7 of this order to evaluate whether their treatment needs can be met in the assigned placements, and, should such evaluation suggest that required treatment cannot be met, recommend an appropriate alternative placement; 9) Based on the review described in paragraph 8, on or before 10/31/03, the special master shall recommend to the court whether the DTP/ICF

Date Filed	#	DOCKET TEXT
		prgram at CMF may be closed; 10) on or before 9/1/03, dfts shall complete and approve a training program and instructional materials for institutional clinicians on all of DMH's inpatient program resources available to CDC clinicians, the crteria for admission to various programs and procedures and the documentation required to refer and obtain transfer for clinically eligible inmates; 11) On or before 9/30/03, dfts shall schedule and complete the training described in paragraph 10; 12) dfts shall forthwith implement the recommendations of the special master's experts contained in the Report on Suicides Completed in the CA Dept of Corrections in Calendar Year 2001 and set forth by the special master at pages 288 and 289 of the 11th Monitoring Report [1519-1] (cc: all counsel) (ndd) (Entered: 07/25/2003)
		* * * *
10/20/2003	1548	ORDER by Honorable Lawrence K. Karlton ORDERING that the special master's request for extension of time [1546-1] is GRANTED; the special master's psychiatric experts shall work with dfts to design an acceptable assessment

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		process and shall participate in the conduct of that process, which shall be completed so as to allow the special master to make recommendations to the court concerning the closure of the DTP/ICF programs by 12/31/03; the special master shall file his recommendations concerning closure of the DTP/ICF programs on or before 12/31/03 (cc: all counsel) (ndd) (Entered: 10/20/2003)
		* * * *
12/09/2003	1553	TWELFTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS, POLICIES AND PROTOCOLS by movant J Michael Keating Jr (sk) (Entered: 12/10/2003)
12/09/2003	1554	EXHIBITS by movant J Michael Keating Jr regarding twelfth monitoring report [1553-1] (sk) (Entered: 12/10/2003)
		* * * *
1/12/2004	1559	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts shall include statustics on contracted registered nurses in their monthly reports on contracted sevice submitted to the monitor; dfts need to identify and provide a list monthly

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		to the monitor of all enhanced outpatient (EOP) inmates in CDC who have been referred to a Psychiatric Services Unit (PSU) and are awainting endorsement by the Classification and parole Representative (CPR); within 60 days from the date of this order, dfts shall develop and submit to the monitor a plan for expediting the endorsement and transfer of EOP inmates who have been referred to a PSU; dfts shall complete their study of unmet inpatient bed needs by 3/31/04; within two weeks from the date of this order, dfts shall submit to the monitor in writing an explanation for the length of stay in administrative segregation for each of the 34 EOP inames held for six months or more and identified in section $10 of the 10/3/03 Health Care Population Unit's Management Information Report; dfts shall make clinical and custody staff aware of the danger of suicide among vulnerable Correctional clinical Case Management System (3CMS) and non-caseload inmates, who are subject to exceptional external stressors due to safety concerns, serious medical conditions, or adverse court rulings and disseminate among all staff with direct daily contacts with

general population and administrative segregation inmates a list of those stressors most commonly associated with suicide and self-injury; dfts shall increase and improve communication and join decision-making between clinical and custody staff about the placement of vulnerable and distressed inmates in alternative living circumstances; both policies and training shall encourage a broad range of collaborative efforts to ensure that the clinical, custodial, and safety needs of vulnerable inmates subject to extraordinary stressors are met; dfts shall undertake an effort to develop objective "outcome measures" for evaluating the training actually provided to local staff in response to the requirements of a suicide-related corrective action plan (CAP); dfts shall continue to work on the development of focused, specific CAPs in response to completed suicides and on the development of an effective mechanism for monitoring and enforcing institutional implementation of CAPs; dfts shall provide the special master with a description of the methods and outcome of any review or investigation that the dept may require of deficient staff

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		practices that the suicide review process identifies as possibly contributing to a completed suicide [1553-1] (cc: all counsel) (ndd) Modified on 03/25/2004 (Entered: 01/12/2004)
		* * * *
6/3/2004	1583	SPECIAL MASTER'S REPORT by J Michael Keating Jr on the dfts' unmet inpatient bed needs study and interim recommendations on closure of the dept of mental health's day treatment program and intermediate care facility at the CA Medical facility (crf) (Entered: 06/04/2004)
		* * * *
06/18/2004	1587	THIRTEENTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS, POLICIES AND PROTOCOLS by movant J Michael Keating Jr (sk) (Entered: 06/21/2004)
06/18/2004	1588	EXHIBITS by movant J Michael Keating Jr THIRTEENTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS, POLICIES AND PRO-

Date Filed	#	DOCKET TEXT
		TOCOLS [1587-1] (sk) (Entered: 06/21/2004)
		* * * *
7/6/2004	1593 –	SUPPLEMENTAL SPECIAL MASTER'S REPORT on the dfts' unmet inpatient bed needs study and interim recommendations on closure of the dept of mental health's day treatment program and intermediate care facility at the CA Medical Facility (mdk) (Entered: 07/07/2004)
07/09/2004	1594	ORDER by Honorable Lawrence K Karlton: not later than 7/30/04, defendants, with assistance of special master's expert(s), shall complete design for & submit to special master a plan for executiion of an unmet inpatient bed needs study; not later than 8/13/04, special master shall review proposed study design and plan & report to Court on its adequacy; if plan approved by Court, study shall completed not later than 90 days after such approval; no later 7/30/04, defendants shall: implement their interim proposal for weekly documented reviews of potential referrals to DMH inpatient care/develop & submit to special matter a comprehensive plan for effectively educating institutional clinicians in all CDC

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		Enhanced Outpatient Programs, Psychiatric Services Units, and Mental Health Crisis Bed units/and shall develop & submit to special master a comprehensive plan for managing and monitoring admission process for all DMH inpatient programs; special master shall report on adequacy of plan in 8/13/04 Report to Court (cc: all counsel) (mm1) (Entered: 07/09/2004)
		* * * *
7/27/2004	1598	ORDER by Honorable Lawrence K. Karlton ORDERING that dfts shall develop brand new plans to bring CSP/Corcoran, HDSP, RJD and SVSP into compliance with their respective corrective action plans, the program guides, and the plans, policies and protocols provisionally approved by this court in mid-1997 (see order for details) (cc: all counsel) (hk) (Entered: 07/27/2004)
8/16/2004	1599	SPECIAL MASTER'S REPORT by movant J Michael Keating Jr on the status of the defendants' unmet inpatient bed needs assessment (sk) (Entered: 08/17/2004)
		* * * *
10/05/2004	1607	ORDER by Honorable Lawrence K. Karlton ORDERING that the special master's 9/2/04 Recommen-

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		dation [1602-1] is adopted in full; dfts shall forthwith conduct an assessment of any unmet need for Dept of Mental Health inpatient beds among seriously mentally disordered inmates in the CA Dept of Corrections pursuant to the methodology approved by the special master and appended to his recommendation filed 9/2/04; dfts shall complete said assessment by 3/15/05 and dfts shall submit to the special master by 3/31/05 their plan to meet any unmet need for inpatient care documented in the assessment (cc: all counsel) (ndd) (Entered: 10/05/2004)
		* * * *
10/28/2004	1626	MINUTES of Evidentiary Hearing before Honorable Lawrence K. Karlton: court in session with all counsel present; court indicates that the proper name of this case is *Coleman v Schwarzenegger*; governor of this State is dft in this matter; witness Ms R Toirac sworn/testified on direct by plts; dft's exam witness R Toirac; follow up by plt; nothing further; witness is excused; court invites defense to call any other witness they feel compelled to call at this time; none called; court calls the representative for the Dept of

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		Mental Health to take the stand; John Rodriguez, Deputy Director of Dept of Mental Health (for state hospitals, sworn/testified on direct by plts; cross-exam by defense; nothing further, witness excused; court in recess; plts calls M Hedricks, sworn/testified on direct; cross-exam by defense; nothing further, witness excused; court in recess; plts calls Dr T Fishback (Chief Psychiatrist/Chief of Mental Health Svc), sworn/testified on direct; nothing further, witness excused; no further witness called; court sets matter for further arguments on [1617-1]; further arguments SET for 1:30 11/19/04; dft's motion to modify the court order is denied; there is an order in place and it remains in place; C/R C Bodene (ndd) (Entered: 10/29/2004)
10/29/2004	1624	ORDER by Honorable Lawrence K. Karlton ORDERING after hearing, the court finds it appropriate to defer ruling on dfts' motion [1617-1] pending consideration by the special master of the issues raised therein; between now and the time set for oral argument, see infra, plts and appropriate officials with the CDC, the Dept of Health Services and Dept of Mental Health, shall

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		participate in discussions with the special master in an effort to limit, narrow, or resolve the issues presented by dfts' motion; oral argument set for 1:30 11/19/04; all orders of this court remain in full force and effect (cc: all counsel) (ndd) (Entered: 10/29/2004)
		* * * *
01/27/2005	1638	ORDER on Motion to Modify Licensure of Intermediate care facility/day treatment program at CMF, Vacaville 1637 signed by Judge Lawrence K. Karlton on 1/26/05: Dfts' proposed plan is approved and may be implemented forwith, with the movement of inmate/patients into their respective program locations to begin by 1/24/05. Plts' counsel and the special master shall submit written comments on the draft MOUs to the dfts by 1/19/05. The dfts shall submit any proposed revision to the MOUs to plts' counsel and the special master by 1/31/05, for inclusion in a final version of the MOUs. should initial, actual operations of the expanded ICF/DTP at CMF indicate the need for any further modifications of the MOUs, the dfts shall submit proposed revisions to plts' counsel and the special master by 4/29/05.

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		CDC and DMH shall prepare jointly and submit a written report to the special master on the status of implementation of the expanded ICF/DTP at CMF on 1/31/05. Thereafter, the dfts will submit a status report on the progress of implementation every two weeks until the expanded programs are fully implemented. The status reports, at a minumum, will provde information on staffing and physical renovations, as well as each program's census and any waiting lists. (Duong, D) (Entered: 01/27/2005)

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03/08/2005	1654	ORDER signed by Judge Lawrence K. Karlton on 3/7/05 re 1649 Fourteenth Monitoring Report ORDERING that the Special Master's Recommendations are Approved (SEE ORDER FOR ALL DETAILS) (Krueger, M) (Entered: 03/08/2005)

* * * *

04/28/2005	1658	STATUS REPORT 5th Suicide Report by J Michael Keating, Jr. (Attachments: # 1 Exhibit Expert's Report# 2 Appendix Case Reviews) (Keating, Joseph) (Entered: 04/28/2005)

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Date Filed	#	DOCKET TEXT
5/6/2005	1661	NOTICE by J Michael Keating, Jr re 1654 Order Special Master's Report on Defendants' Schedule of Differential Pay for Mental Health Clinicians in Specific California Department of Corrections Institutions. (Keating, Joseph) (Entered: 05/06/2005)

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Date Filed	#	DOCKET TEXT
6/10/2005	1667	ORDER signed by Judge Lawrence K. Karlton on 6/9/05 ORDERING Dfts to include an increase in the compensation for the position of chief psychologist in their scheduled R and R enhancements for CA State Prison/Corcoran. On 1/1/06 the dfts shall report to the Special Master the status of their recruitment efforts at CSP/Corcoran. The Special Master shall review and assess the dfts' status report and, by 2/15/06, report to the Court the impact of the dfts revised R and R schedule on the recruitment of clinicians and recommend specific remedies, including his own enhanced R and R schedule, if the institution's staffing vacancy problems have not been resolved during the interim. (Krueger, M) (Entered: 06/10/2005)
6/10/2005	1668	ORDER signed by Judge Lawrence K. Karlton re Suicide Report 1658 ORDERING that w/in 60 days dfts

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		shall submit to the Special Master (SM) a plan for dealing w/the hazard of ventilation screens. W/in 60 days dfts shall develop/implement a policy regarding life support. Dfts shall provide the SM a summary of methods/outcomes of investigations whenever the suicide review process refers members of the mental health/medical/or custody staff, initially judged to have been responsible for some act of incomepetence, malfeasance or negligence, to another investigatory and/or disciplinary channel. W/in 90 days HCS of CDC shall develop as a part of the suicide review procees a procedure to ensure the implementation of remedies. W/in 60 days dfs shall develop a plan for tracking the suicidal history of inmates. (Krueger, M) (Entered: 06/10/2005)
		* * * *
01/23/2006	1746	FIFTEENTH MONITORING REPORT OF THE SPECIAL MASTER by Matthew A Lopes, Jr. (Attachments: # 1 Supplement pages 101-200# 2 Supplement pages 201-300 # 3 Supplement pages 301-400 # 4 Supplement pages 401-end # 5 Exhibit # 6 Exhibit # 7 Exhibit # 8 Exhibit # 9 Exhibit # 10 Exhibit # 11 Exhibit) (Keating, Joseph)

Date Filed	#	DOCKET TEXT
		Modified on 1/24/2006 (Kirkpatrick, S). (Entered: 01/23/2006)
		* * * *
02/03/2006	1749	Special Master's Report and Recommendations on dfts' Revised Program Guide. (Keating, Joseph) Modified on 2/6/2006 (Duong, D). (Entered: 02/03/2006)
		* * * *
02/03/2006	1753	January 2006 Revised Program Guide, Chapters 1 Through 10 Including Glossary by dfts (Attachments: # 1 Appendix 1 # 2 Appendix 2 # 3 Appendix 3 # 4 Appendix 4 # 5 Appendix 5 # 6 Appendix 6 # 7 Appendix 7 # 8 Appendix 8 # 9 Appendix 9 # 10 Appendix 10) (Tillman, Lisa) Modified on 2/6/2006 (Duong, D). (Entered: 02/03/2006)
02/03/2006	1754	Supplemental Notice including Chapter 2 in January 2006 Revised Program Guide. (Tillman, Lisa) Modified on 2/6/2006 (Duong, D). (Entered: 02/03/2006)
		* * * *
02/14/2006	1761	RESPONSE by dfts Schwarzenegger, *et al* to Special Master's Final Report and Recommendations on Revised Program Guide 1749. (Tillman, Lisa) Modified on 2/15/2006 (Duong, D). (Entered: 02/14/2006)

Date Filed	#	DOCKET TEXT
2/15/2006	1762	REPORT on the Impact of dfts' Increases in differential pay for mental health clinicians in CA State Prison, Corcoran by J Michael Keating, Jr. (Attachments: # 1 Exhibit A # 2 Exhibit B) (Keating, Joseph) Modified on 2/16/2006 (Duong, D). (Entered: 02/15/2006)

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Date Filed	#	DOCKET TEXT
03/03/2006	1772	ORDER signed by Judge Lawrence K. Karlton on 3/2/06 ORDERING W/in 60 days of this order dfts shall submit to the special master a plan for reducing rate of vacancies among psychiatrists system-wide; W/in 60 days of this order dfts shall submit to the special master a plan to expand the DCHCS central office mental health staff commensurate w/ the growth and present size of the CDCR mental health staff and caseload; Dfts shall file plans for provisions no later than 4/17/06; Dfts shall provide to special master and to pltfs weekly reports on the status of development of the plans required by paragraphs 3 and 5 of this order, w/ the first report to be provided by 3/10/06. On or before 3/17/06, dfts shall file a response to the second and third objections raised in pltfs' 2/3/06 objections to the special master's fifteenth round

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		monitoring report. This matter is SET for 4/26/2006 at 3:00 PM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (*See* order for further details) (Girgis, C) (Entered: 03/03/2006)
03/03/2006	1773	ORDER signed by Judge Lawrence K. Karlton on 3/2/06 ORDERING The Provisions of the 1/2006 Revised Program Guide is GRANTED and orders dfts to immediately implement all such provisions. Status Conference SET for 4/26/2006 at 03:00 PM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (*See* order for further details) (Girgis, C) (Entered: 03/03/2006)
3/9/2006	1774	ORDER re 1762 signed by Judge Lawrence K. Karlton on 3/9/06 ORDERING that defendants shall be given until 5/15/06 to reduce the vacancy rate among all categories of mental health personnel at CSP-Corcoran, including psychiatrist, case managers, psych techs, recreational techs and supervisory clinicians, to 10 percent or less through the employement of permanent staff and/or contract providers. Dfts shall file a report with the court no later than 5/22/06, which sets for the vacancy rate as of 5/15/06 for each category of mental health personnel

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		at CSP-Corcoran, including psychiatrists, case managers, psych techs, recreational techs and supervisory clinicians. Dfts shall take all measures necessary, beginning immediately, to ensure that in the event that it is necessary to implement the R & R enhancements specified in this order, that any and all administrative steps, including but not limited to the Dept of Personnel Administration letter authorizing the specific enhancements, will be completed so that hiring with the new enhancements can begin no later than 6/6/06 (*See* Order for details). (Duong, D) (Entered: 03/09/2006)
		* * * *
4/26/2006	1795	MINUTES for proceedings held before Judge Lawrence K. Karlton: EVIDENTIARY HEARING held on 4/26/2006. Witnesses: Doug McKeever, George Sifuentes, John Rodriguez. Evidentiary Hearing set for 4/27/2006 at 09:15 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. Plaintiffs Counsel Michael Bien, Jane Kahn, Tom Nolan, Keith Wattley present. Defendants Counsel Lisa Tillman, Rochelle East present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 04/27/2006)

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4/27/2006	1797	MINUTES for proceedings held before Judge Lawrence K. Karlton: EVIDENTIARY HEARING held on 4/27/2006. Witnesses: Doug McKeever, Sarah Magnum, George Sifuentes, John Rodriguez, Dr. Peter Farber-Szekrenyi, Jim Alves. Special Master Michael Keating addresses the Court. Court Order to follow. Further Status Conference re discovery set for 5/17/2006 at 01:30 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. Plaintiffs Counsel Michael Bien, Jane Kahn, Tom Nolan, Keith Wattley present. Defendants Counsel Lisa Tillman, Rochelle East present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 04/28/2006)
		* * * *
5/2/2006	1800	ORDER signed by Judge Lawrence K. Karlton on 5/1/06 ORDERING that the dfts' long term plan for provision of acute and intermediate inpatient care and mental health crisis beds is approved, subjection to modification based on current population projections. Within 60 days from the date of this order dfts shall file an amended long term plan that is based on current population projections and incorporate

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		an updated version of methodology first adopted in the 2002 Tucker-Alan bed needs projections. The dfts' long term plan for enhanced outpatient beds describes a shortfall of over 1000 such beds in the year 2011 and therefore is not approved. Dfts shall include the amended long term plan a list of those projects that can be accelerated as well as a list of any statutory, licensing, or staffing barriers to such acceleration and/or to timely opening of the projects described in the amended long term plan. Within 45 days from the date of this order, dfts shall file a plan for interim provision of intermediate inpatient beds and mental health crisis beds. Plts are granted a period of ten days in which to file and serve a response to the interim plan required by paragraph 3 of this order. Dfts shall maintain 36 intermediate inpatient beds at the CA Medical Facility (CMF) P-2 until further order of court. In connection therewith, dfts are reminded of their obligations under the heat plan developed pursuant to prior orders of this court, and dfts are directed to take every mechanical step presently feasible to maintain appropriate temperatures within said unit. Not

later than 5/30/06, dfts shall open 36 intermediate inpatient beds at Salinas Valley State Prison (SVSP) that were slated to receive inmates from CMF. Said beds shall be used for Leavel IV inmates. Dfts shall create an additional 36 intermediate inpatient beds at SVSP on the same time schedule and with the same waivers used to create the 36 beds referred to in paragraph 7 of this order. Said beds also be used for Level IV inmates. Dfts shall forthwith review the list of 123 inmates presently awaiting placement in the intermediate inpatient bed program at SVSP and shall identify all inmates on said list approprite for placement in the DMH program at Atascadero State Hospital or Coalinga State Hospital. Twenty-Five intermediate inpatient beds shall be made immediately available at Coalinga State Hospital for appropriate CDCR inmates. Within 30 days thereafter, an additional 25 intermediate inpatient beds shall be made available at Coalinga State Hospital for appropriate CDCR inmates. Within 6 months from the dte of this order, dfts shall file a report on the feasibility and cost of creating 30 intermediate inpatient beds at Coalinga

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		State Hospital beds for Level IV high-custody CDCR inames. Said report shall be prepared by the CDCR in collaboration with DMH and the CA Dept of General Services. Dfts shall activate the mental health crisis beds in the correctional treatment centers at KVSP and CA State Prison-Sacramento not later than 7/1/06, or inform the court in writing by that date why said centers are not fully operational. Dfts shall forthwith reopen the locked observation unit at the CA Men's Colony as a 36 bed mental health crisis bed unit on a temporary emergency basis. Said mental health crisis beds shall remain in use until further order of this court. Until further order of this court, dfts shall not close any intermediate inpatient bed or mental health crisis bed on the basis of state licensing requirements without approval of the special master. (*See* order for details). (Duong, D) (Entered: 05/02/2006)
		* * * *
5/2/2006	1802	ORDER to SHOW CAUSE signed by Judge Lawrence K. Karlton on 5/1/06 ORDERING that within 15 days from the date of this order, Stephen W. Mayberg, Ph.D.,

Date Filed	#	DOCKET TEXT
		Director of the CA Dept of Mental Health, and/or any party to this action may show cause in writing if any there is, why Director Mayberg should not be joined as a defendant in this action. Clerk is directed to serve a copy of this order on Steph W. Mayberg, Ph.D., Director, CA Dept of Mental Health, 1600 9th Street, Rm 151, Sacramento, CA 95814. (cc: Stephen w. Mayberg, Ph.D.) (Duong, D) (Entered: 05/02/2006)
05/02/2006	1803	ORDER signed by Judge Lawrence K. Karlton on 5/1/06 re 1746 ORDERING that plts' second and third objections to the special master's 15th round monitoring report 1750 1763 are overruled. Within 90 days from the date of this order, dfts shall file a plan for providing adequate mental health care for inmates in reception centers who have been identified as requiring an enhanced outpatient program (EOP) leavel care who remain in reception centers for longer than 60 days. (Duong, D) (Entered: 05/02/2006)

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05/22/2006	1820	DEFENDANT(S) Report on the Status of Mental Health Vacancies at CSP, Corcoran by Schwarzenegger, *et al.* (Attachments: # 1 Exhibit

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		A) (Tillman, Lisa) Modified on 5/23/2006 (Brown, T). (Entered: 05/22/2006)
		* * * *
6/8/2006	1830	ORDER signed by Judge Lawrence K. Karlton on 6/7/06 re 1806 ORDERING that on or before 8/31/2006, dfts shall develop a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and depending on the outcome of the analysis, provide adequate resources of meantal health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units. The plan shall include, as appropriate, a budget and implementation schedule for any policy and procedure changes, staffing or budget augmenttation, and, if necessary, include a mechanism for obtaining mid-year funding on or before 9/30/006. Dfts shall collaborate with one or more of the special master's experts, with plts' counsel and with plts' expert, Lindsay Hayes, to develop the plan

Date Filed	#	DOCKET TEXT
		required by this order. (Duong, D) (Entered: 06/08/2006)
06/21/2006	1851	SPECIAL MASTER'S REPORT (Attachments: #(1) Exhibit A #(2) Exhibit B #(3) Exhibit C #(4) Exhibit D) (Hinkle, T) Modified on 7/28/2006 (Kirkpatrick, S). Modified on 7/28/2006 (Kirkpatrick, S). (Entered: 06/21/2006)
		* * * *
6/28/2006	1855	ORDER signed by Judge Lawrence K. Karlton on 6/27/06 ORDERING that Stephen M. Mayberg, Ph.D., Director of the Dept of Mental Health is JOINED as a defendant in the action. He is joined only in his official capacity. Clerk directed to serve a copy of this order on Stephen W. Mayberg, Ph.D., Director, CA Dept of Mental Health, 1600 9th Street, Rm. 151, Sacramento, CA 95814. (Duong, D) (Entered: 06/28/2006)
		* * * *
07/20/2006	1904	ORDER re 1902 signed by Judge Lawrence K. Karlton on 7/20/06 ORDERING that this Court waives CA Public Contract Code section 10808 and dft Dept of corrections and Rehabilitation to approve the physical modifications of the Locked Observation Unit at CA

Date Filed	#	DOCKET TEXT
		Men's Colony. (Duong, D) (Entered: 07/20/2006)
		* * * *
07/28/2006	1921	SPECIAL MASTER'S SUPPLEMENTAL REPORT (Attachments: #(1) Exhibit A; #(2) Exhibit B; #(3) Exhibit C) (Hinkle, T) Modified on 7/28/2006 (Kirkpatrick, S). (Entered: 07/28/2006)
		* * * *
8/1/2006	1929	AMENDED ORDER signed by Judge Lawrence K. Karlton on 7/28/06 ORDERING Michael Genest, Director of CA Dept. of Finance, is joined in his official capacity as a dft in this action. Clerk is directed to serve copy of this order on Mr. Genest. Dfts shall prepare and present to the special session of the Legislature, scheduled to occur in August 2006, a budget proposal for the allocation of no less than the 530.65 permanent and 21.2 limited term positions. (See order for further details) Clerk is directed to unseal 1851, 1881, 1882, 1883, 1891, 1892, 1893, 1910, 1918, and 1921. Clerk is directed to serve copy of Special Master's supplemental report and attached exhibits filed 7/28/06 w/ copy of this order on Robert Sillen, Michael Bien, and

Date Filed	#	DOCKET TEXT
		Lisa Tillman. (Girgis, C) (Entered: 08/01/2006)
		* * * *
8/8/2006	1937	STIPULATION and ORDER re Revision of Suicide Policy Permitting Video Monitoring of Inmates on Suicide Watch Status signed by Judge Lawrence K. Karlton on 8/8/06 re 1872 ORDERING that dfts shall provide the Special Master and plts with 45 days written notice of any decision to reinstate video-monitoring as the sole method of conducting suicide watch observation at any CDCR institution. If plts' counsel object to the reinstatement, the parties shall meet and confer within 20 days. If disputed issues remain, plts may notice a hearing before the District Court on shortened time to resolve the matter. (Duong, D) Modified on 8/8/2006 (Duong, D). (Entered: 08/08/2006)
		* * * *
08/10/2006	1950	PROPOSED ORDER re Stipulation re ASH/CMF Bed Plan 1949 by James Gomez, Joseph Sandoval, Schwarzenegger, Stephen W Mayberg, Michael Genest, John S Zil, MD, Nadim Khoury. (Tillman, Lisa) Modified on 8/11/2006 (Duong, D). (Entered: 08/10/2006)

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08/11/2006	1951	STIPULATION and PROPOSED ORDER re: Clinical Competency of Psychiatrists, Confidentiality of Identifying Information by James Gomez, Joseph Sandoval, Schwarzenegger, *et al*, Stephen W Mayberg, Michael Genest, John S Zil, MD, Nadim Khoury. (Tillman, Lisa) (Entered: 08/11/2006)
		* * * *
08/23/2006	1962	ORDER re ASH/CMF Bed Plan signed by Judge Lawrence K. Karlton on 08/23/06 re 1950 ORDERING that This court approves the parties' stipulation and so orders the dfts' submitted CMF/ASH plan be implemented immediately, with the following conditions: The utilization of the beds subject to this plan will be monitored for twelve months, with the evaluative marker of 90% or higher bed utilization during this period of time. At the end of the twelve-month monitoring period, the parties shall meet and confer with Special Master Keating to discuss the continued implementation of this plan in light of the bed utilization statistics and other relevant clinical factors. Defendants DMH and CDCR are to provide Plaintiffs' counsel and Special Master Keating with a monthly utilization

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		report by the fifteenth day of the following month concerning the 25 ASH APP beds, the 25 bed CMF MHCB unit, and the remaining CMF APP unit. The monthly report should contain the following information: number of patient referrals, number of patient rejections, patient-inmate transfer time frames, number of patient acceptances, identities of patients, each patient's length of stay and discharge date, the source of referrals by institution, and the reason for rejection. Defendants are to provide Plaintiffs' counsel and Special Master Keating for review and comment a copy of the uniform referral form for acute beds provided by DMH for referrals from CDCR. This uniform referral form will be used for all referrals to all acute beds provided by the DMH to CDCR inmates. Defendants DMH and CDCR will do system-wide training on the policies and procedures for inpatient referrals as well as the care provided by the intermediate and acute programs. Defendants DMH and CDCR will provide Plaintiffs' counsel and Special Master Keating with a copy of the training materials for comment before the training occurs. This Court leaves it to the discretion of

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		Special Master Keating to have one or more of his experts attend the training. If there is no patient waiting or using the new MHCB beds at CMF, then those beds may be used to provide acute care. (Duong, D) Modified on 8/24/2006 (Duong, D). (Entered: 08/23/2006)
		* * * *
09/11/2006	1968	STIPULATION and ORDER signed by Judge Lawrence K. Karlton on 09/08/06 re 1951 ORDERING that this court has reviewed the first portion of the above stipulation of the parties concerning language to insert in the Revised Program Guide to address the clinical competency of psychiatrists and hereby adopts it as an order of this court. This court has reviewed the second portion of the above stipulations of the parties concerning the sealing of information containing or indicating the confidential nature of the identities of those CDCR psychiatrists hire before 2006 who do not meet minimum credentialing criteria. The court approves the stipulated seal and makes it an order of the court. (Duong, D) (Entered: 09/11/2006)
09/11/2006	1969	SUPPLEMENTAL STATUS REPORT by Special Master J. Michael Keating, Jr. (Attachments: # 1

Date Filed	#	DOCKET TEXT
		Exhibit A # 2 Exhibit B # 3 Exhibit C # 4 Exhibit D # 5 Exhibit E) (Keating, Joseph) Modified on 9/12/2006 (Krueger, M). (Entered: 09/11/2006)
		* * * *
10/02/2006	1990	DEFENDANTS' Plan to Address Suicide Trends in Administrative Segregation Units. (Attachments: # 1 Exhibit) (Tillman, Lisa) Modified on 10/3/2006 (Matson, R). Modified on 10/3/2006 (Duong, D). (Entered: 10/02/2006)
		* * * *
10/20/2006	1998	ORDER signed by Judge Lawrence K. Karlton on 10/20/06 ORDERING that the revised recommendations of the Special Master 1994 are ADOPTED in full. The program population projections in the revised and updated Navigant Study are approved. Defendants shall contract with Navigant Consultants to conduct annual population reviews and updates of their projections for mental health program populations from 2007 through 2009. Thereafter, defendants may obtain such population projections services through the normal contract bidding process. The Navigant service contract shall be controlled and super-

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		vised by the California Department of Corrections and Rehabilitation's (CDCR) Division of Correctional Health Care Services rather than the CDCR's Division of Legal Affairs. The Special Master, and such of his experts as he may assign to the task, shall work with the defendants and Navigant to improve the projections and ensure that all necessary data is collected to make future projections as accurate as possible. The Special Master shall monitor closely the swap of acute inpatient beds between California Medical Facility and Atascadero State Hospital and any delays in the transfer of seriously mentally disordered inmates to mental health crisis beds within 24 hours of a clinical referral and report to the court in writing on these two issues within ninety days. Within sixty days from the date of this order defendants shall file a final long plan for the provision of acute and intermediate inpatient beds, as well as a plan for the provision of enhanced outpatient program (EOP) beds, for all seriously mentally ill male and female CDRC inmates clinically determined to be in need of those levels of care. These consolidated plans shall meet or exceed

the program population projections contained in the approved Navigant study and shall include a process for regular updates of bed need projections and ongoing planning for new mental health beds based on subsequently revised projections. Defendants' plan shall also address the feasibility of a "Design and Build" approach for the construction projects specified in the consolidated plan and shall coordinate the use of such an approach with any related Design and Built efforts in the Plata case. Defendants' consolidated plan shall include a timetable, budget planning and resource allocations to meet projected populations by June 30, 2011. The consolidated plan shall also include construction of the 50- bed mental health crisis bed unit at California Men's Colony proposed in defendants' revised interim bed plan. Defendants shall accelerate implementation of their plan for new EOP treatment programs in CDCR Reception Centers so the proposed programs become operational by January 1, 2007. Defendants shall add treatment programs for EOP inmates in the Reception Center at California State Prison, Los Angeles County, in addition to the five reception centers enumer-

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		ated in the original plan. The Special Master shall monitor the added EOP services provided in the six institutions covered in the plan and report to the court by June 30, 2007 whether the program needs to be extended to any other CDCR Reception Centers. Defendants' interim plan for the temporary establishment of 76 inpatient intermediate Department of Mental Health (DMH) beds in the D-5 and D-6 units at Salinas Valley State Prison and 30 beds in the P-3 Wing at California Medical Facility is approved. The Special Master shall review these programs, as well as the other intermediate inpatient DMH programs opened in California Medical Facility and Salinas Valley State Prison pursuant to the defendants' interim plan and report to the court by March 31, 2007 on the defendants' success in implementing these interim programs. (See Order for details). (Duong, D) (Entered: 10/20/2006)
		* * * *
11/3/2006	2021	MINUTES (Text Only) for proceedings held before Judge Lawrence K. Karlton: MOTION HEARING held on 11/3/2006 re 2016 MOTION for TEMPORARY RESTRAINING

Date Filed	#	DOCKET TEXT
		ORDER filed by Plaintiffs. After oral arguments, the Court will allow the plane to depart. Defendants are ordered to conduct thorough interviews of all the inmates that are bound for Tennessee in the manner outlined by Special Master Michael Keating. In Court Hearing set for 11/9/2006 at 08:30 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. Defendants to submit a proposed order. Plaintiffs Counsel Michael Bien, Donald Specter present. Defendants Counsel Lisa Tillman present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 11/03/2006)
		* * * *
11/06/2006	2025	ORDER signed by Judge Lawrence K. Karlton on 11/6/2006 ORDERING: 2016 MOTION for TEMPORARY RESTRAINING ORDER and Preliminary Injunction To Enjoin Defendants Illegal Transfers filed by Ralph Coleman is DENIED; Dfts are to place an appropriately-credentialed mental health clinician employed by CDCR on the scheduled flight w/the 80 inmates. Please refer to order for full details. (Matson, R) (Additional attachment(s) added on 3/6/2009: # 1

Date Filed	#	DOCKET TEXT
		Exhibit 1) (Donati, J). (Entered: 11/06/2006)
		* * * *
11/08/2006	2029	REPORT TO THE COURT REGARDING OUT-OF-STATE TRANSFERS by dfts. Attachments: # 1 Exhibit 1 # 2 Declaration of Tim Rougeux # 3 Declaration of Shama Chaiken # 4 Declaration of Margaret McAloon) (Tillman, Lisa) Modified on 11/16/2006 (Carlos, K). (Entered: 11/08/2006)
		* * * *
11/13/2006	2036	MOTION To Convene a Three Judge Panel to Limit the Prison Population by Ralph Coleman. Motion Hearing set for 12/11/2006 at 10:00 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (Bien, Michael) (Entered: 11/13/2006)
		* * * *
11/13/2006	2038	DECLARATION of Michael W. Bien in Support Of re 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population. (Attachments: # 1 Exhibit A-C# 2 Exhibit D# 3 Exhibit E-F# 4 Exhibit G# 5 Exhibit H-K# 6 Exhibit L-N# 7 Exhibit O-V# 8 Exhibit W-AA# 9

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		Exhibit BB-DD) (Bien, Michael) (Entered: 11/13/2006)
		* * * *
11/13/2006	2041	MEMORANDUM/RESPONSE in SUPPORT re 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population. (Bien, Michael) (Entered: 11/13/2006)
		* * * *
12/01/2006	2061	RESPONSE by dfts to Plaintiffs' Objections to Submitted Plan to Address Suicide Trends in Administrative Segregation Units 2006 (Attachments: # 1 Exhibit A# 2 Exhibit B# 3 Exhibit C# 4 Exhibit D) (Tillman, Lisa) Modified on 12/4/2006 (Kirkpatrick, S). Modified on 12/5/2006 (Duong, D). (Entered: 12/01/2006)
		* * * *
12/04/2006	2063	MEMORANDUM/RESPONSE in OPPOSITION to Plaintiffs' Motion to Convene a Three Judge Panel to Limit the Prison Population 2036 (Attachments: # 1 Declaration of Lisa Tillman) (Tillman, Lisa) Modified on 12/5/2006 (Duong, D). (Entered: 12/04/2006)
		* * * *

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12/13/2006	2078	TRANSCRIPT of Motion to Convene a Three Judge Panel held on 12/11/06 before Judge Lawrence K. Karlton. Court Reporter: Catherine E. Bodene. (TEXT ONLY) (Brown, T) (Plummer, M). (Entered: 12/13/2006)

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Date Filed	#	DOCKET TEXT
12/14/2006	2081	SIXTEENTH MORNITORING REPORT by J Michael Keating, Jr. (Attachments: # 1 Part 2 of Report page 50-100 # 2 Part 3 of Report page 100-150 # 3 Part 4 of Report page 151-200 # 4Part 5 of Report page 201-250 # 5 Part 6 of Report page 251-300 # 6 Part 7 of Report page-300-350 # 7 Exhibits A-D # 8 Exhibits E-I # 9 Exhibits J-M # 10 Exhibits N-R # 11 Exhibit S-U) (Keating, Joseph) (Additional attachment(s) added on 3/10/2009: # 11 Exhibits S-U) (Donati, J). Modified on 3/10/2009 (Donati, J). (Entered: 12/14/2006)
12/15/2006	2082	SUPPLEMENT to the Sixteenth Monitoring Report 2081 by J Michael Keating, Jr. Part 8 of Report pages 351-400. (Attachments: # 1 Part 9 of Report pages 401-435) (Keating, Joseph) Modified on 12/15/2006 (Duong, D). (Entered: 12/15/2006)

Date Filed	#	DOCKET TEXT
12/15/2006	2083	ORDER signed by Judge Lawrence K. Karlton on 12/15/06 re 2081 ORDERING that defendants shall forthwith adopt and implement the proposed schedule of pay for CDCR mental health clinicians contained in Exhibit T to the special master's sixteenth round monitoring report. The provisions of California Government Code sections 19816, 19826, 19829, 19832, 19836, 3516.5 and 3517, and California Code of Regulations Title 2, section 599.681 are waived solely for the purpose of implementing the proposed salaries and structural changes set forth in said Exhibit T. The terms of the salary proposal, once adopted, shall supersede all existing R&R compensation provided to any and all of the indicated job classifications, as well as psychiatrist longevity pay provided in pay differential 325. (Duong, D) (Entered: 12/15/2006)
12/18/2006	2084	REPORT AND RECOMMENDATION on dfts' Plan to Prevent Suicides in Administrative Segregation by J Michael Keating, Jr. (Keating, Joseph) Modified on 12/19/2006 (Duong, D). (Entered: 12/18/2006)

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Date Filed	#	DOCKET TEXT
12/19/2006	2091	STATEMENT of Defendants' Submission of Final Long Range Bed Plan by Defendants James Gomez, Joseph Sandoval, Schwarzenegger, et al, Matthew A Lopes, Jr, Stephen W Mayberg, Michael Genest, John S Zil, MD, Nadim Khoury. (Tillman, Lisa) (Entered: 12/19/2006)
		* * * *
01/25/2007	2119	ORDER signed by Judge Lawrence K. Karlton on 1/25/07 re conference on 1/18/07: The parties to each of the above-captioned cases are informed that the special master in *Coleman*, the receiver in *Plata*, and, if and when appointed, a representative of the court in *Perez* will hold monthly meetings for the purpose of working collaboratively on issues related to coordination of the remedies in each of the above-captioned actions. The parties to each action will be permitted to submit, in advance of the meetings, proposed agenda items consideration by the special masters, the receiver and the *Perez* court representative. The undersigned will continue to meet on a quarterly basis with the special master in *Coleman*, the receiver in *Plata*, and the court representative in *Perez* to further facilitate the coordination of the remedial process

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		in these cases. (Duong, D) (Entered: 01/25/2007)
		* * * *
01/30/2007	2121	STATUS REPORT on plts' Response to the 16th Report on compliance seeking salary enhancements for Dept of Emntal Health Clinicians 2085 by J Michael Keating, Jr. (Attachments: # 1 Exhibit A # 2 Exhibit B) (Keating, Joseph) Modified on 2/1/2007 (Duong, D). (Entered: 01/30/2007)
		* * * *
02/07/2007	2133	STATUS REPORT by J Michael Keating, Jr. (Keating, Joseph) (Entered: 02/07/2007)
		* * * *
02/12/2007	2139	ORDER signed by Judge Lawrence K. Karlton on 2/9/07 ORDERING that: dfts' 10/2/06 plan, as amended in their 12/1/06 filing, is approved subject to the further report of the special master; dfts shall implement said plan; the special master shall meet with dfts and pltfs' counsel monthly to follow up, refine and monitor implementation of each element of the dfts' plan; and w/in 90 days from the date of this order, the special master shall report back to the court on the status of dfts'

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		compliance with the plan and shall make such further recommendations as may be necessary. (Brown, T) (Entered: 02/12/2007)
02/14/2007	2140	SPECIAL MASTER 17TH MONITORING REPORT - PART A by J Michael Keating, Jr. (Attachments: # 1 Supplement # 2 Supplement # 3 Exhibit A-C # 4 Exhibit D-G # Supplement - REMOVED PER REQUEST OF SPECIAL MASTER (Keating, Joseph) Modified on 2/15/2007 (Brown, T). Modified on 2/16/2007 (Holland, K). Modified on 4/20/2010 (Owen, K). (Entered: 02/14/2007)
		* * * *
03/01/2007	2154	ORDER signed by Judge Lawrence K. Karlton on 02/28/07 re 2150 ORDERING that dfts' ex parte Motion for order approving additional beds at CMF and CIW and approving temporary space at Mule Creek State Prison 2148 is GRANTED and so orders dfts to implement the proposals. (Duong, D) (Entered: 03/01/2007)
		* * * *
03/09/2007	2156	ORDER signed by Judge Lawrence K. Karlton on 3/9/07 ORDERING that the supplemental report of the special master filed 1/22/07 is

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		ADOPTED in full. The special master shall continue to monitor the swap program and, on or before 5/1/07, report again in writing on the status of defendants' interim measures to relieve the mental health crisis bed shortage and make such recommendations as are appropriate at that time. (Engbretson, K.) (Entered: 03/09/2007)
3/12/2007	2157	ORDER signed by Judge Lawrence K. Karlton on 3/9/07 re 16th Report 2081 2082 ORDERING that defendants shall review their "Procedures for Mental Health Assessment of Inmate Indecent Exposure and Treatment for Exhibitionism," dated October 10, 2004. Defendants shall consider the concentration of the CDCR's inmates with exhibitionism or a paraphilia associated with exhibitionist behaviors in a smaller number of regional institutions in order to focus staff with requisite training and skills to provide the treatment services not presently available in many CDCR institutions. Institutions shall be provided with specific direction on the appropriate security measures that need to be adopted, including, if deemed necessary, a requirement for the creation of an internal high-level

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		custody and mental health committee to review local residents involving indecent exposure or exhibitionism. Defendants shall inaugurate a re-thought, fully staffed program for inmates with exhibitionism or a paraphilia associated with exhibitionist behaviors in at least three institutions by July 1, 2007. (Duong, D) (Entered: 03/12/2007)
3/12/2007	2158	ORDER signed by Judge Lawrence K. Karlton on 3/9/05 re 17th Report 2140 ORDERING that Defendants shall implement forthwith paragraph 4 of this court's order dated March 7, 2005 which required defendants to collect data and report on referrals and transfers to Department of Mental Health (DMH) programs. If the defendants are unable to do so, they shall file within thirty days a report specifying the reasons for their inability to comply together with a plan for coming into compliance with the March 7, 2005 order 1654 within the following sixty days. If defendants have not come into compliance with the March 7, 2005 order within ninety days from the date of this order, they will be ordered to show cause why they

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		should not be held in contempt of court. Defendants' failure to comply with this order and paragraph 4 of the March 7, 2005 order will not be excused by lack of a computerized system capable of generating the data needed for the required report; the necessary data and summaries may be collected and prepared manually. Within ninety days from the date of this order defendants shall develop a mechanism for compiling accurate data on referrals and transfers to more intensive levels of California Department of Corrections and Rehabilitation (CDCR) mental health treatment, including referrals and transfers to Mental Health Crisis Bed Units, Mental Health Outpatient Hospital Units, Psychiatric Services Units, Enhanced Outpatient Program hub administrative segregation hub units and Enhanced Outpatient Programs from Reception Centers. Each CDCR institution shall record and track the dates of referrals and transfers to each of these programs. Each institution shall also prepare and submit monthly to the Division of Correctional HealthCare Services an institutional summary of all referrals and transfers, including those pending as well as all refer-

rals, rejections and transfers that occurred during the preceding month, within twenty days of the end of each month. Defendants shall work with the special master's experts to review the provision of Enhanced Outpatient Programs (EOPs) in administrative segregation units. The review process shall conduct an audit of the EOP administrative segregation population and examine more effective ways for reducing the lengths of stay of EOP inmates in administrative segregation; alternative methods for the delivery of mental health treatment, including the use of a different mix of clinical and paraclinical professionals; the use of different housing and/or service models for particular categories of EOP administrative segregation inmates; and any other strategy or approach likely to better serve the treatment needs of EOP administrative segregation inmates. The study shall result in a brief report, prepared within ninety days from the date of this order, which shall be shared with parties, counsel and the court. (Duong, D) (Entered: 03/12/2007)

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03/27/2007	2173	ORDER signed by Judge Lawrence K. Karlton on 03/26/07 ORDERING that The special master's report 2133 is ADOPTED. Defendants shall complete and occupy the 50-bed mental health crisis bed units at California Medical Facility and California Men's Colony as soon as possible. Within ninety days defendants shall provide to the special master a detailed report on how CDCR's assumption of responsibility for services presently provided to class members by DMH will be accomplished and, if further study suggests such assumption of responsibility is not feasible, what alternative(s) will be pursued. (Duong, D) (Entered: 03/27/2007)
		* * * *
03/28/2007	2178	ORDER signed by Judge Lawrence K. Karlton on 03/28/07 re 2176 ORDERING that this Court has reviewed dfts' ex parte motion for an order approving the plan to construct twenty permanent psychiatric services unit (PSU) beds at California Institution for Women. Upon good cause appearing, the Court hereby grants the ex parte motion 2175 and orders implementation of the plan forthwith. (Duong, D) (Entered: 03/28/2007)

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04/02/2007	2180	SPECIAL MASTER 17TH MONITORING REPORT - PART B by J Michael Keating, Jr. (Attachments: # 1 Supplement Pages 49-99# 2 Supplement Pages 100-111# 3 Exhibits A-E# 4 Exhibit F) (Keating, Joseph) Modified on 4/3/2007 (Matson, R). Modified on 4/20/2010 (Owen, K). (Entered: 04/02/2007)
		* * * *
04/12/2007	2186	SPECIAL MASTER'S REPORT on dfts' Establishment of Interim Inpatient Intermediate Dept of Mental Health Beds and the need for approval of some basic component of dfts' Revised Dec 2006 Bed Plan by J Michael Keating, Jr. (Attachments: # 1 Exhibit A - California Department of Mental Health Vacaville Psychiatric Program Memorandum Dated April 9, 2007) (Keating, Joseph) Modified on 4/12/2007 (Duong, D). Modified on 4/13/2007 (Kaminski, H). (Entered: 04/12/2007)
		* * * *
04/17/2007	2200	ORDER signed by Judge Lawrence K. Karlton on 04/17/07 ORDERING that The special master's report 2186 is ADOPTED in full. By June 15, 2007, defendants shall file a

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		supplemental report which addresses two issues: CDCR's relationship with DMH and CDCR's consolidation plan. This supplemental report supersedes the report required in the court's March 27, 2007 order 2178. (Duong, D) Modified on 4/19/2007 (Duong, D). Modified on 4/23/2007 (Duong, D). (Entered: 04/17/2007)
		* * * *
05/01/2007	2208	SUPPLEMENT by J Michael Keating, Jr. (Attachments: # 1 Exhibit 1) (Keating, Joseph) Modified on 5/2/2007 (Plummer, M). (Entered: 05/01/2007)
		* * * *
05/17/2007	2221	ORDER signed by Judge Lawrence K. Karlton on 5/17/2007 ORDERING This matter is set for hearing on June 4, 2007 on plaintiffs' motion to convene a three judge panel to limit the prison population pursuant to 18 U.S.C. ? 3626(a)(3). Good cause appearing, the special master shall provide the information to the court, on or before May 31, 2007. (Reader, L) (Entered: 05/17/2007)
		* * * *

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5/23/2007	2236	ORDER signed by Judge Lawrence K. Karlton on 5/23/2007 ORDERING w/in 3 weeks from the date of this order, dfts shall file with the court a plan to provide pay at parity with the pay scales approved by the court in its 12/15/06 order for all DMH psychiatrists, psychologists, licensed clinical social workers, and psychiatric technicians providing care to members of the Coleman class at any state run facility, whether such facility is a DMH hospital or a CDCR prison institution; w/in 3 weeks from the date of this order, dfts shall consider and report to the court on the feasibility of other options for forthwith remedying the limitation on admission of Coleman class members to Atascadero State Hospital caused by the staffing shortage, including but not limited to contracting with outside psychiatrists and other necessary psychiatric staff to provide sufficient staffing for the Coleman beds at Atascadero State Hospital; w/in 3 weeks from the date of this order, dfts shall file a report identifying the job titles and number of staff members required, pursuant to applicable staffing ratios, to provide care to; w/in 1 week thereafter, pltfs shall file and serve a response to the

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		plan and the report required by paragraphs 1 and 2 of this order; w/in 3 weeks from the date of this order, dfts shall file, concurrently with the plan required by the previous paragraph of this order, a first month report of referrals, pending referrals, rejections, and transfers, of inmates from any level of outpatient mental health care to any level of inpatient mental health care, and from any level of inpatient mental health care to a different level of mental health care. 2165 (Reader, L) (Entered: 05/23/2007)
05/23/2007	2237	ORDER signed by Judge Lawrence K. Karlton on 5/23/2007 ORDERING the Special Master's 5/1/07 2208 Supplemental Report and recommendations contained therein are adopted in full; the bed swap between California Medical Facility and Atascadero State Hospital is reversed; and the 25 beds at Atascadero State Hospital that were included in the swap shall be returned to use as mental health crisis beds for *Coleman* class members. (Reader, L) (Entered: 05/23/2007)
05/24/2007	2238	DEFENDANTS' Supplemental Brief in Opposition to Plaintiffs' Motion for Referral to a Three-Judge Panel re

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		2209 Order. (Attachments: # 1 Attach to Supp Brief - List of Acronyms #(2) Exhibit A # 3 Exhibit B # 4 Declaration D Hysen # 5 Declaration K Jett # 6 Declaration S Kernan # 7 Declaration M McAloon # 8 Declaration D McKeever # 9 Declaration J Petersilia) (Tillman, Lisa) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)
05/24/2007	2239	PLAINTIFFS' Supplemental brief in SUPPORT of Motion to Convene a Three Judge Panel to Limit Prison Population. (Bien, Michael) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)
05/24/2007	2240	DECLARATION of Lori Rifkin in SUPPORT OF 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population. (Attachments: # 1 Exhibit A-C# 2 Exhibit D-G# 3 Exhibit Exhibit H pp 1-150 # 4 Exhibit H p 151-300# 5 Exhibit H p 301-476# 6 Exhibit I-M# 7 Exhibit N-V# 8 Exhibit W-CC) (Bien, Michael) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)

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05/24/2007	2242	DECLARATION of Ernest Galvan in SUPPORT OF 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population.

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		(Attachments: # 1 Exhibit A-D # 2 Exhibit E-H # 3 Exhibit I-K # 4 Exhibit L-T # 5 Exhibit U-V # 6 Exhibit W) (Bien, Michael) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)
05/24/2007	2243	DECLARATION of Holly Baldwin in SUPPORT OF 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population and Exhibits A-D. (Bien, Michael) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)
05/24/2007	2244	MEMORANDUM/RESPONSE in SUPPORT OF 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population. (Bien, Michael) Modified on 5/25/2007 (Matson, R). (Entered: 05/24/2007)

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05/29/2007	2248	ORDER to SHOW CAUSE signed by Judge Lawrence K. Karlton on 05/29/07 ORDERING that on or before June 4, 2007, the parties in the above captioned cases shall show cause in writing why the pending motions to limit the prison population should not be heard jointly at one hearing before the undersigned. All responses to this order to show cause shall be filed in each of the above-captioned cases

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		and served on all of the parties to each action and on the Plata Receiver and the Coleman Special Master. The hearings set in the two cases are vacated and will be reset following resolution of the instant order to show cause. (Duong, D) (Entered: 05/29/2007)
		* * * *
05/30/2007	2251	CORRECTED SUPPLEMENTAL BRIEF in SUPPORT of 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population. (Bien, Michael) Modified on 5/31/2007 (Kirkpatrick, S). (Entered: 05/30/2007)
		* * * *
05/31/2007	2253	REPLY/RESPONSE by J Michael Keating, Jr. *To Court's May 17, 2007 Request for Information* (Attachments: # 1 Exhibits A-D to Special Master's Response to Court's May 17, 2007 Request for Information) (Keating, Joseph) Modified on 6/1/2007 (Plummer, M). (Entered: 05/31/2007)
05/31/2007	2254	RESPONSE to ORDER to SHOW CAUSE by Ralph Coleman. (Bien, Michael) (Entered: 05/31/2007)
		* * * *

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06/13/2007	2274	SPECIAL MASTER 17TH MONITORING REPORT - PART C by J Michael Keating, Jr. (Attachments: # 1 Part 2 # 2 Part 3 # 3 Part 4 # 4 Exhibits A-D # 5 Exhibits E-I # 6 Exhibit J) (Keating, Joseph) Modified on 6/14/2007 (Engbretson, K.). Modified on 4/20/2010 (Owen, K). (Entered: 06/13/2007)
		* * * *
06/15/2007	2285	RESPONSE to Proposed Agreements of May 29, 2007 Order 2248 by dfts. Attorney East, Rochelle C. added. (East, Rochelle) Modified on 6/18/2007 (Engbretson, K.). Modified on 6/18/2007 (Duong, D). (Entered: 06/15/2007)
		* * * *
06/27/2007	2298	MINUTES (Text Only) for proceedings held before Judge Lawrence K. Karlton and Judge Thelton E. Henderson: JOINT MOTION HEARING (C01-1351 TEH) held on 6/27/2007 re 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population filed by Ralph Coleman. After oral argument, the matters stand SUBMITTED. Courts to issue formal order. Plaintiffs Counsel Michael Bien, Jane Kahn, Lori Rifkin, Donald Specter present. Defendants Counsel Lisa Tillman,

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		Misha Igra, Rochelle East and Paul Mello present. Ronald Yank for CCPOA. Michael Keating and Matthew Lopes present. Robert Sillen and John Hagar present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 06/27/2007)
		* * * *
06/28/2007	2300	ORDER signed by Judge Lawrence K. Karlton on 6/28/07 APPROVING the six identified coordination agreements and ORDERING that the receiver shall henceforth file in *Coleman* quarterly progress reports and *Perez* quarterly progress reports. (Donati, J) (Entered: 06/28/2007)
6/28/2007	2301	ORDER signed by Judge Lawrence K. Karlton on 6/28/07 ORDERING that the Defendants shall forthwith implement the pay scales for DMH clinicians set forth in their 6/14/07 response to this court's 5/23/07 order. Within 30 days from the date of this order, defendants shall file with the court a plan for making available up to 125 intermediate care beds for *Colemant* class members referred to ASH for treatment. On or before 11/30/07, defendants shall file with the special master a plan for making available the full complement of 231 intermediate care beds for *Coleman* class members

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		referred to ASH for treatment. The defendants shall continue to provide the special master with monthly reports on the information required by paragraph 5 of this court's 5/23/07 order. The department shall, in its report, inform the court of the name and job description of the person having immediate responsibility for insuring compliance with the court's order. (Donati, J) (Entered: 06/28/2007)
07/02/2007	2302	STATUS REPORT by J Michael Keating, Jr. (Keating, Joseph) (Entered: 07/02/2007)
07/02/2007	2303	STATEMENT of Defendants' Further Statement Addressing Plaintiffs' Motion To Convene A Three-Judge Panel to Address Population Issues by Defendant Schwarzenegger, *et al.* (Attachments: # 1 Exhibit 1(A) # 2 Exhibit 1(B) # 3 Exhibit 1(C) # 4 Exhibit 1(D) # 5 Exhibit 1(E)) (Tillman, Lisa) (Entered: 07/02/2007)

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Date Filed	#	DOCKET TEXT
07/12/2007	2313	RESPONSES and Objections to Special Master Keating's Report on Defendants' Plan to Provide Enhanced Outpatient Program Care at Reception Centers 2302 by dfts. (Tillman, Lisa) Modified on 7/13/2007 (Duong, D). (Entered: 07/12/2007)

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07/23/2007	2320	ORDER signed by Judge Lawrence K. Karlton on 7/23/07 GRANTING 2036 Motion to convene a three-judge panel to limit the prison population. The clerk is directed to serve a copy of this order on the Chief Judge of the 9th Circuit Court of Appeals. (Donati, J) (Entered: 07/23/2007)
		* * * *
07/26/2007	2328	ORDER signed by Chief Judge of the Ninth Circuit Mary M. Schroeder on 7/26/07 GRANTING 2320 Request for Apointment of a single three-judge distict court pursuant to 28 USC 2284. It is hereby DESIGNATED and APPOINTED that Honorable Stephen Reinhardt, US Circuit Judge for the Ninth Circuit, to sit with the Honorable Lawrence K. Karlton and the Honorable Thelton E. Henderson to hear and determine the above entitled causes. (Donati, J) (Entered: 07/26/2007)
		* * * *
07/30/2007	2334	SPECIAL MASTER 18TH MONITORING REPORT by J Michael Keating, Jr. (Attachments: # 1 Supplement # 2 Supplement # 3 Supplement # 4 Supplement # 5

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		Supplement # 6 Supplement # 7 Exhibit # 8 Exhibit # 9 Supplement # 10 Supplement) (Keating, Joseph) Modified on 4/20/2010 (Owen, K). (Entered: 07/30/2007)
		* * * *
07/31/2007	2339	SPECIAL MASTER'S PSYCHIATRIC EXPERTS' REVIEW of Completed Suicides in the California Department of Corrections and Rehabilitation in Calendar Years 1999 through 2004 by J Michael Keating, Jr. (Holland, K) (Entered: 07/31/2007)
		* * * *
08/02/2007	2345	ORDER signed by Judge Lawrence K. Karlton on 8/2/07 ORDERING that within 60 days from the date of this order dfts shall develop a plan for identifying and developing the changes deemed necessary to broaden the impact of the mental health assessment process in prison disciplinary matters on 3CMS inmates, testing those changes and implementing them systemwide. The plan shall be submitted to the special master and to pltfs' counsel for review and comment. The special master shall report to the court on the adequacy of this plan and make any appropriate recom-

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		mendations in the next regularly scheduled monitoring report. Within 60 days from the date of this order, dfts shall develop a plan, funding proposal and timetable for implementing an effective staff recruitment capability and strategy. The special master shall report to the court on the adequacy of this plan and make any appropriate recommendations in the next regularly scheduled monitoring report, unless in his judgment court action with respect to the plan is required at an earlier date. (Kastilahn, A) (Entered: 08/02/2007)
		* * * *
08/15/2007	2372	DEFENDANT(S) STATUS REPORT by James Gomez, Joseph Sandoval, Schwarzenegger, et al, Matthew A Lopes, Jr, Stephen W Mayberg, Michael Genest, John S Zil, MD, Nadim Khoury. Attorney Mello, Paul B added. (Mello, Paul) (Entered: 08/15/2007)
		* * * *
08/17/2007	2375	SUPPLEMENT by James Gomez, Joseph Sandoval, Schwarzenegger, et al, Matthew A Lopes, Jr, Stephen W Mayberg, Michael Genest, Paul Cook, Gregg Cohen, John S Zil, MD, Nadim Khoury. Attorney Tillman,

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		Lisa Anne added. *DEFENDANTS' SUPPLEMENTAL BED REPORT* (Attachments: # 1 Exhibit A) (Tillman, Lisa) (Entered: 08/17/2007)
		* * * *
10/03/2007	2450	ORDER signed by Judge Lawrence K. Karlton on 10/2/2007 ORDERING that the 7/2/2007 recommendations of the special master, as revised and supplemented on 8/15/2007, are ADOPTED IN FULL. (Matson, R) (Entered: 10/03/2007)
		* * * *
10/09/2007	2453	ORDER signed by Judge Lawrence K. Karlton on 10/5/07 ORDERING that effective 11/1/07, Atty Matthew A. Lopes, Jr. shall assume the duties and responsibilities of the special master in this action as outlined in the court's 12/11/95 order, and shall be compensated at the rates set forth in this order. Effective 11/1/07, Attys Linda E. Buffardi and Mohamedu F. Jones shall serve as deputy special masters in this action and shall be compensated at the rates set forth in this order. (Kastilahn, A) (Entered: 10/09/2007)
		* * * *

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10/18/2007	2461	ORDER signed by Judge Lawrence K. Karlton on 10/17/07 ORDERING that the special master's report 2432 is ACCEPTED in FULL and his recommendations ADOPTED as modified herein. Defendants' August 2007 supplemental bed plan is approved. The special master shall report to the court in his twentieth round monitoring report on the status of defendants' efforts to meet fully the projected needs for female enhanced outpatient and enhanced outpatient-administrative segregation unit beds. Plaintiffs' request for an order mandating ongoing and close supervision of the consolidated care center construction plans and programmatic design plans for compliance with the Americans with Disabilities Act and other federal laws is denied without prejudice. Plaintif's request for an expedited time frame for planning for and completion of adequate mental health treatment and counseling space at California Medical Facility and Salinas Valley State Prison is DENIED. Defendants are granted a period of thirty days from the date of this order to determine whether the Joint Commission on Accreditation of Healthcare Organizations provides accreditation for

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		intermediate care beds in a non-hospital prison setting. Assuming that it does, within six months thereafter defendants shall submit to the special master a plan with timeframes for meeting and procuring for all California Department of Corrections and Rehabilitation-operated inpatient programs applicable State licensure and accredittation by the Joint Commission on Accreditation of Healthcare Organizations. Within six months from the date of this order, defendants shall submit to the special master the following plans as listed. Within 120 days from the date of this order defendants shall submit to the special master a development proposal for adequate mental health treatment and counseling space at Salinas Valley State Prison. Within 150 days from the date of this order defendants shall submit to the special master a development proposal for adequate mental health treatment and counseling space at California Medical Facility. (Duong, D) (Entered: 10/18/2007)

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01/16/2008	2644	ORDER signed by Judge Lawrence K. Karlton on 1/15/08: This court's June 1, 2007 2255 and September

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		14, 2007 2418 orders are modified to require the completion of a total of 1,162 small management yards in administrative segregation by the end of Fiscal Year 2008/2009. Defendants' October 29, 2007 plan for small management yards in administrative segregation is disapproved to the extent that it calls for completion of such yards by January 2010. Defendants shall take all steps necessary to complete the construction of all remaining yards called for by their plan by the end of Fiscal Year 2008/2009. Within thirty days from the date of this order, defendants shall report to the court on the outcome of their review of available sensitive need yards for CCCMS inmates within administrative segregation units and their review of submitting a request for additional staffing allocations to enable third watch small management yard usage by inmates within administrative segregation housing. (Kaminski, H) (Entered: 01/16/2008)

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02/26/2008	2696	ORDER signed by Senior Judge Lawrence K. Karlton, Judge Thelton E. Henderson, Judge Jeffrey S. White and Judge Claudia Wilken on 2/26/08: The construction agreement

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		appended to this order is approved. The Plata Receiver shall file quarterly reports in each of the above-captioned cases concerning developments pertaining to matters that are the subject of the construction agreement. The first such quarterly report shall be filed on or before March 15, 2008. Within sixty days from the date of this order the Plata Receiver shall meet with the parties to all of the above-captioned actions, the *Coleman* Special Master, and the *Perez* and Armstrong court representatives concerning the status of the construction of 5,000 mental health beds and 5,000 medical beds that is the subject of paragraph 3 of the construction agreement. (Kaminski, H) (Entered: 02/26/2008)
02/26/2008	2697	ORDER signed by Senior Judge Lawrence K. Karlton on 2/26/08: Approval of the construction agreement does not relieve defendants of their obligation to comply with this courts March 27, 2007 order regarding that unit. Defendants in this case remain bound by that order unless and until it is modified by this court for good cause shown. This court recognizes the complexities of the task at hand, but cautions that defendants must not

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		lose sight of the immediate needs of members of the plaintiff class even as they work to plan long-range solutions to the problems that continue to plague the delivery of constitutionally adequate mental health care to all class members. (Kaminski, H) (Entered: 02/26/2008)
		* * * *
03/10/2008	2711	ORDER signed by Senior Judge Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White and Claudia Wilken on 3/10/08 ORDERING that the attached coordination agreement regarding information technology is approved. The *Plata* Receiver shall coordinate with DMH to facilitate technological compatibility and communication regarding patient care between DMH and CDCR. The *Plata* Receiver shall file quarterly reports in each of the above-captioned cases concerning developments pertaining to matters that are the subject of the information technology agreement. The first such quarterly report shall be filed on or before 6/15/08. (Anderson, J) (Entered: 03/10/2008)
		* * * *
04/01/2008	2739	ORDER signed by Senior Judge Lawrence K. Karlton, Judge Thel-

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		ton E. Henderson and Judge Jeffrey S. White on 4/1/08 ORDERING that the attached coordination agreement regarding the Chief Executive Officer pilot program is approved. The *Plata* Receiver shall file quarterly reports in each of the above-captioned cases concerning developments pertaining to matters that are the subject of the Chief Executive Officer pilot program agreement. The first such quarterly report shall be filed on or before June 15, 2008. (Duong, D) (Entered: 04/01/2008)
		* * * *
04/16/2008	2757	AMENDED ORDER signed by Senior Judge Lawrence K. Karlton on 04/15/08 ORDERING that dfts' 2752 ex parte motion to amend their December 2006 mental health bed plan, as supplemented by the bed plan of August 2007, to indicate that the 50-bed mental health crisis bed facility at California Mens Colony will be built without any consolidated care center at that campus is GRANTED. (Benson, A) (Entered: 04/16/2008)
		* * * *
06/09/2008	2814	JOINT STATUS CONFERENCE STATEMENT. (Mello, Paul) Modified

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		on 6/10/2008 (Duong, D). (Entered: 06/09/2008)
		* * * *
07/25/2008	2895	SPECIAL MASTER'S 19th MONITORING REPORT by Matthew A Lopes, Jr. (Attachments: # 1 report part II, # 2 Report part III, # 3 Exhibit, # 4 Exhibit, # 5 Exhibit) (Lopes, Matthew) (Entered: 07/25/2008)
7/25/2008	2896	MINUTES (Text Only) for proceedings held before Senior Judge Lawrence K. Karlton: MOTION HEARING held on 7/25/2008 re 2842 MOTION Injunctive Relief Requiring Timely Access to Inpatient Psychiatric Hospitalization filed by Ralph Coleman, 2840 MOTION for Leave to File Consolidated Motion and Request for Modification of Protective Orders filed by Ralph Coleman. After oral argument, the Court to issue an order. Plaintiffs Counsel Lori Rikin, Ernest Galvan, Michael Bien, Jane Kahn present. Defendants Counsel Lisa Tillman present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 07/25/2008)
		* * * *
09/12/2008	3029	SPECIAL MASTER'S 20th MONITORING REPORT-PART A by

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		Matthew A Lopes, Jr. (Attachments: # 1 Supplement 14-50, # 2 Supplement 51-100, # 3 Supplement 101-150, # 4 Supplement 151-200, # 5 Supplement 201-250, # 6 Supplement 251-300, # 7 Supplement 301-350, # 8 Supplement 351-364, # 9 Exhibit 365-414, # 10 Exhibit 415-465, # 11 Exhibit 466-516, # 12 Exhibit 517-522)(Lopes, Matthew) Modified on 9/12/2008 (Matson, R). (Entered: 09/12/2008)
09/12/2008	3030	SPECIAL MASTERS REPORT on suicides of 2006 by Matthew A Lopes, Jr. (Attachments: # 1 Exhibit Case Reviews, # 2 Exhibit Case Reviews, # 3 Exhibit Case Reviews, # 4 Exhibit Case Reviews, # 5 Exhibit Case Reviews, # 6 Exhibit Appendix C) (Lopes, Matthew) Modified on 9/12/2008 (Reader, L). (Entered: 09/12/2008)

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9/29/2008	3061	DECLARATION of Craig Haney, PhD in Opposition to 3033 Motion to Dismiss or, Alternatively, Summary Judgment or Summary Adjudication. (Whelan, Amy) Modified on 9/30/2008 (Yin, K). (Entered: 09/29/2008)

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Date Filed	#	DOCKET TEXT
9/29/2008	3063	DECLARATION of Dr. Pablo Stewart in Opposition to 3033 *Motion to Dismiss or, Alternatively, Summary Judgment or Summary Adjudication*. (Attachments: # 1 Exhibit C (through Appendix C), # 2 Exhibit C (through Appendix D), # 3 Exhibit C (through Appendix F)) (Whelan, Amy) Modified on 9/30/2008 (Yin, K). (Entered: 09/29/2008)
		* * * *
10/07/2008	3072	ORDER signed by Senior Judge Lawrence K. Karlton on 10/6/08. Defendants shall do the following: 1) develop a plan to address overall dysfunction in custody/mental health relations at Salinas Valley State Prison (SVSP) - within 90 days from date of this Order ; 2) develop a plan for maximum utilization of all dormitory beds at SVSP - within 90 days from date of this Order; 3) implement and maintain institutional electronic and manual tracking logs for inmates who have been placed into alternative housing pending Mental Health Crisis Bed (MHCB) transfers, and dates, times, and places of return to regular housing for inmates not transferred to an MHCB; 4) construct the mental health treatment and counseling space at SVSP and the

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		mental health treatment and programming space at California Medical Facility (CMF) as described in their development Proposals submitted in response to this Courts 10/18/07 Order; and 5) shall disseminate complete Coleman Monthly Report of Information Requested and Response to 1/19/1999 Court Order regarding Staff Vacancies and CDCR Mental Health Crisis Bed Monthly Report on a regular and timely basis. (Marciel, M) (Entered: 10/07/2008)
10/07/2008	3073	ORDER signed by Senior Judge Lawrence K. Karlton on 10/7/08 approving attached Space Coordination Agreement. (Marciel, M) (Entered: 10/07/2008)
		* * * *
10/20/2008	3101	MOTION IN LIMINE *No. 1 To Exclude Evidence Re: Housing And Other Environmental Conditions, Safety Concerns, And Programmatic Concerns* by Schwarzenegger, Stephen W Mayberg, James E. Tilton, Matthew Cate. (Mello, Paul) (Entered: 10/20/2008)
		* * * *
10/30/2008	3201	STATEMENT of Expert Report of Professor Craig Haney by Plaintiff

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		Ralph Coleman. (Kahn, Jane) (Entered: 10/30/2008)
		* * * *
10/30/2008	3217	STATEMENT of Expert Report of Pablo Stewart, M.D. by Plaintiff Ralph Coleman. (Kahn, Jane) (Entered: 10/30/2008)
		* * * *
10/30/2008	3221	STATEMENT of Supplemental Expert Report of Pablo Stewart, M.D., and Appendix A-D (part 1) by Plaintiff Ralph Coleman. (Attachments: # 1 Appendix D (part 2) - F)(Kahn, Jane) (Entered: 10/30/2008)
		* * * *
01/08/2009	3444	STATEMENT of Continuation of Deposition Designations and Counter-Designations by Plaintiff Ralph Coleman re 3443 Statement. (Attachments: # 1 Exhibit 4, # 2 Exhibit 5, # 3 Exhibit 6A, # 4 Exhibit 6B, # 5 Exhibit 6C, # 6 Exhibit 7, # 7 Exhibit 8)(Morris, Maria) (Entered: 01/08/2009)
		* * * *
01/08/2009	3450	STATEMENT of Continuation of Deposition Designations and Counter-Designations by Plaintiff Ralph Coleman re 3446 Statement, 3448 Notice - Other - ATY, 3447 State-

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		ment, 3445 Statement, 3444 Statement, 3449 Statement, 3443 Statement. (Attachments: # 1 Exhibit 26A, # 2 Exhibit 26B, # 3 Exhibit 27, # 4 Exhibit 28A, # 5 Exhibit 28B, # 6 Exhibit 28C, # 7 Exhibit 29, # 8 Exhibit 30)(Morris, Maria) (Entered: 01/08/2009)
		* * * *
02/02/2009	3503	JOINT STATEMENT re Coordination Agreement Regarding Transition, Activation and Management of 10,000 Bed Project by Receiver J. Clark Kelso. (Dodd, Martin) Modified on 2/3/2009 (Plummer, M). (Entered: 02/02/2009)
		* * * *
2/3/2009	3505	ORDER to SHOW CAUSE signed by Senior Judge Lawrence K. Karlton on 2/2/09: The parties are granted five days from the date of this order to show cause, if any they have, why this court should not require defendants to continue to operate, on a temporary emergency basis, all mental health crisis beds at CIM-GACH as presently operated and at current staffing levels until further order of this court. (Kaminski, H) (Entered: 02/03/2009)
		* * * *

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02/17/2009	3515	ORDER signed by Senior Judge Lawrence K. Karlton on 2/17/09 re 3513 ORDERING that defendants to file and serve a statement setting forth the present bed plan not later than fifteen days from the date of this order. Plaintiffs may respond not later than fifteen days thereafter. An evidentiary hearing is SET for March 24, 2009 at 1:30 PM. (Duong, D) (Entered: 02/17/2009)
02/17/2009	3516	ORDER signed by Senior Judge Lawrence K. Karlton on 2/17/09 ORDERING that defendants operate, on an emergency basis, the mental health crisis beds at CIM-GACH as presently operated and at current staffing levels until further order of this court. (Duong, D) (Entered: 02/17/2009)

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03/05/2009	3540	ORDER signed by Senior Judge Lawrence K. Karlton on 3/5/2009 ORDERING that the defendants are directed to work immediately and with full dispatch on the development of a plan, so the financial aspects thereof can be included in the upcoming budget process if necessary. Defendants shall provide a written report on the progress w/i 10 days. The report shall specify the names of each person who is

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		responsible for development of the plan, and exactly what they have been doing from the date of receipt of this order. Response shall also include the address of each person, as well as their title. Defendants shall inform the court in the report of the status of the 50-bed Mental Health Crisis unit at California Men's Colony. The hearing SET for 3/24/2009 will now be for the purpose of considering what further steps are required to insure timely compliance. Defendants will have present the leading persons specified in the report. (Waggoner, D) (Entered: 03/05/2009)
		* * * *
03/19/2009	3544	DEFENDANT(S) STATUS REPORT by Schwarzenegger. (Tillman, Lisa) (Entered: 03/19/2009)
		* * * *
03/31/2009	3556	ORDER signed by Senior Judge Lawrence K. Karlton on 3/30/09 ORDERING that Within 30 days from 3/24/09, dfts shall take all steps necessary to have executed contracts, and shall file appropriate declarations; Within 30 days from the date of this order, dfts shall file a detailed schedule for completing, opening, and filling the 64-bed ICF

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		at SVSP, open for occupancy not later than 6/15/09, and dfts shall file a certification attesting thereto not later than 5 days thereafter; On or before 5/26/09, dfts shall file with the court and submit to the special master and pltfs detailed activation schedules for completion of all other court ordered construction projects. Pltfs will be granted until 6/9/09 to submit comments to the special master on the activation schedules; Over the next 60 days, dfts shall continue to meet with the special master and, as appropriate in consultation with the *Plata* Receiver, to develop concrete proposals to meet the remaining short-term, intermediate, and long range bed needs. On or before 5/26/09, dfts shall file with the court and submit to the special master and the pltfs a final proposal. Pltfs will be granted until 6/9/09 to submit comments to the special master on the final proposal; this matter is set for Hrg on 6/16/09 at 1:30 p.m. on the adequacy of dfts activation schedules for all court-ordered projects; Dft Mayberg shall attend in person all meetings set by the special master unless the special master determines that dft Maybergs attendance is not required; Within 60 days or on such schedule

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		as the special master may direct, CDCR and DMH clinicians shall work together to conduct a modified assessment to determine whether there are unmet needs for inpatient care among members of the pltf class. (Becknal, R) (Entered: 03/31/2009)
		* * * *
04/28/2009	3573	ORDER Waiving State Law re: Salinas Valley State Prison signed by Senior Judge Lawrence K. Karlton on 4/28/2009. (Matson, R) (Entered: 04/28/2009)
		* * * *
5/5/2009	3575	ORDER signed by Senior Judge Lawrence K. Karlton on 05/05/09 ORDERING that dfts shall report to the court immediately if any of the 3574 dates set for activation of wings in the Salinas Valley State Prison intermediate care facility are delayed for any reason. (Benson, A.) (Entered: 05/05/2009)
		* * * *
06/18/2009	3613	ORDER signed by Senior Judge Lawrence K. Karlton on 6/17/09: The activation schedules for court-ordered projects proposed by defendants are approved and the timeframes set forth in the schedules

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		shall be met. Defendants' long-range plan is not approved. Status Conference is set for 9/22/2009 at 01:30 PM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (Kaminski, H) (Entered: 06/18/2009)

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Date Filed	#	DOCKET TEXT
7/9/2009	3629	ORDER signed by Senior Judge Lawrence K. Karlton on 7/8/09 ORDERING that dfts shall renew the Mental Health Bed Projection Services contract with Navigant Consulting and/or execute a contract with John Misener of McManis Consulting prior to the expiration of the existing contract on 12/31/09. Said contract shall be renewed or executed for a period of three addt'l yrs. Dfts shall report to the Court within 30 days on any remaining actions that must be taken to renew or execute the contract and any barriers to completing all necessary actions remaining to renew or execute the contract by 12/31/09. In the event that dfts determine, at any time, that an applicable state law or regulation must be waived in order to renew or execute the contract by 12/31/09, dfts shall immediately file a motion with this Court identifying any applicable law

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		or regulation that must be waived, and requesting the Court enter an order waiving such provision. (Kastilahn, A) (Entered: 07/09/2009)
		* * * *
07/31/2009	3638	TWENTY-FIRST MONITORING REPORT on the dfts' Compliance with Provisionally Approved Plans, Policies and Protocols of Special Master Matthew A Lopes, Jr. (Attachments: # 1 Exhibit, # 2 Exhibit, # 3 Exhibit, # 4 Exhibit, # 5 Exhibit, # 6 Exhibit, # 7 Exhibit, # 8 Exhibit, # 9 Exhibit, # 10 Exhibit, # 11 Exhibit, # 12 Exhibit)(Lopes, Matthew) Modified on 7/31/2009 (Duong, D). (Entered: 07/31/2009)
07/31/2009	3639	DEFENDANT(S) STATUS REPORT by Schwarzenegger. (Vorous, Debbie) (Entered: 07/31/2009)
		* * * *
09/17/2009	3677	SPECIAL MASTER REPORT on Suicides of 2007 by Matthew A Lopes, Jr. (Attachments: # 1 Exhibit Appendix part 1, # 2 Exhibit Appendix part 2, # 3 Exhibit Appendix part 3, # 4 Exhibit Appendix part 4, # 5 Exhibit Appendix part 5) (Lopes, Matthew) Modified on 9/17/2009 (Reader, L). (Entered: 09/17/2009)
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9/22/2009	3683	MINUTES (Text Only) for proceedings held before Senior Judge Lawrence K. Karlton: STATUS CONFERENCE held on 9/22/2009. Defendants are directed to file, within thirty days, detailed written responses to questions/concerns raised by the Court. Further, within 45 days from today, defendant shall file with the court a detailed plan for completion of the correctional Health Care Facility and for each of the alternative site renovations that are planned to create EOP and EOP administrative segregation beds. Plaintiffs will have twenty days thereafter to file a response to the detailed plan. The court expects that defendant will comply fully with this order. In the event they do not, the court will set an evidentiary hearing at which time the court will hear testimony from persons with knowledge of the reasons or reasons for such non-compliance and from any party or agent who has authority to ensure compliance with this order but who has failed to do so. Court order to follow. Plaintiffs Counsel Michael Bien, Jane Kahn, Amy Whelan, Mark Feeser, Steven Fama present. Defendants Counsel Debbie Vorous, Jeffrey Steele pre-

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		sent. Court Reporter: C. Bodene. (Rivas, A) (Entered: 09/22/2009)
		* * * *
09/24/2009	3686	ORDER signed by Senior Judge Lawrence K. Karlton on 9/24/2009 ORDERING that within 30 days from the date of this order, defendants shall file a written report specifially addressing matters as outlined in the instant order. Within 45 days from the date of the hearing, defendants shall file with the court a detailed long-range plan, including activation schedules; within 20 days after defendants file their detailed long-range plan, plaintiffs may file a response thereto; defendants shall identify any waivers of state law that may by required to complete the projects that comprise the long-range plan, either at the time the plan is filed or as the need for such waiver arises; the burden of requesting any such waiver shall be on the plaintiffs; the court expects defendants to comply in full with this order. In the event of material non-compliance, the court will set an evidentiary hearing at which time the court will hear testimony from any person with knowledge of the reason or reasons for such non-compliance and from

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		any party or agent of any party who has authority to ensure compliancewith this order but who has failed to do so. Paragraph 3(a) of the courts June 18, 2009 order is hereby modified as provided in the instant order. By 9/23/09 notice concerning the 45 additional EOP-ASU beds at CSP-Corcoran, defendants have satisfied their obligation under paragraph 3(a) of the court's 6/18/09 order with respect to the impediment described in the 9/23/09 notice. (Waggoner, D) (Entered: 09/24/2009)
		* * * *
09/30/2009	3693	Defendants' STAFFING PLAN by Schwarzenegger. (Attachments: # 1 Exhibit [Exhibits 1-29]) (Vorous, Debbie) Modified on 10/1/2009 (Plummer, M). (Entered: 09/30/2009)
		* * * *
11/02/2009	3720	STIPULATION and ORDER signed by Senior Judge Lawrence K. Karlton on 11/02/09 ORDERING that The Department of Mental Health shall have until 12/31/09 to comply with the Court's 06/18/09 Order that it fill the full complement of 256 intermediate care beds at Atascadero State Hospital with *Coleman* class members; by 11/30/09, the CDCR Health Care Placement

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		Oversight Program shall review all of the inmate-patients on the waiting list for the Salinas Valley Psychiatric Program at Salinas Valley State Prison using the Pilot Program to determine whether any of the inmate-patients on the list are eligible for admission to Atascadero State Hospital or to the intermediate care program at the Vacaville Psychiatric Program at California Medical Facility; and in accordance with paragraph 11 of the Court's 06/18/09 Order, dfts will report to the Special Master by 12/31/09, on how many additional intermediate care beds, if any, are required for Coleman class members at Atascadero State Hospital or Coalinga State Hospital. (Benson, A.) (Entered: 11/02/2009)
		* * * *
11/06/2009	3724	RESPONSE by Schwarzenegger to 3686 Order. (Attachments: # 1 Exhibit Attachment A) (Vorous, Debbie) Modified on 11/9/2009 (Plummer, M). (Entered: 11/06/2009)
		* * * *
11/23/2009	3731	ORDER signed by Senior Judge Lawrence K. Karlton on 11/20/09 DENYING 3695 Motion to modify 2007 Suicide Report; pltfs request

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		that the recommendations in the 2007 Suicide Report be made an order of this court is denied without prejudice; pltfs request for orders clarifying defendants obligations with respect to production of documents to the special master and admission of CDCR inmates to DMH facilities is denied without prejudice. (Manzer, C) (Entered: 11/23/2009)
11/24/2009	3732	REQUEST for *[Defs’ Request for Waiver of State Law Re: California State Prison, Sacramento]* by Schwarzenegger. (Attachments: # 1 Declaration, # 2 Proposed Order) (Vorous, Debbie) (Entered: 11/24/2009)

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Date Filed	#	DOCKET TEXT
12/08/2009	3744	STIPULATION and ORDER signed by Senior Judge Lawrence K. Karlton on 12/07/09 ORDERING that dfts’ short-term, emergency project to pilot double bunk the inmate-patients in one 10-cell wing in Treatment Center 1 of the Salinas Valley Psychiatric Program at Salinas Valley State Prison, shall be MODIFIED so that the pilot double-bunk project will proceed forward in Treatment Center 2, rather than in Treatment Center 1. (Benson, A.) (Entered: 12/08/2009)

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		* * * *
12/11/2009	3748	ORDER signed by Senior Judge Lawrence K. Karlton on 12/11/09 waiving state law re: California State Prison, Sacramento. (Donati, J) (Entered: 12/11/2009)
		* * * *
12/24/2009	3758	SPECIAL MASTER'S REPORT AND RECOMMENDATIONS by Matthew A Lopes, Jr. (Lopes, Matthew) Modified on 12/24/2009 (Engbretson, K.). (Entered: 12/24/2009)
		* * * *
12/31/2009	3760	MOTION (Request) for *Temporary Relief Re: 256 Intermediate Care Facility Low-Custody Beds at Atascadero State Hospital* by Schwarzenegger. (Attachments: # 1 Declaration Debbie Vorous, # 2 Declaration McGill, # 3 Declaration Radavsky, # 4 Declaration Johnson, # 5 Proposed Order) (Vorous, Debbie) Modified on 1/4/2010 (Yin, K). (Entered: 12/31/2009)
01/04/2010	3761	ORDER signed by Senior Judge Lawrence K. Karlton on 1/4/10 ORDERING that all projects in dfts long-range plan, including the mental health crisis bed project at Stark, are approved with exceptions. Beginning 3/1/10, dfts shall

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		report to the special master on a monthly basis all action taken on each project. Dfts are not required to describe departures from timeframes, as required by paragraph 2 of the court's 6/18/09 order and paragraph 2 of this order, or to report impediments to timely completion of a project, as required by paragraph 6 of the court's 9/24/09 order, unless a departure or an impediment will delay completion of a project by more than 30 days. Dfts' request to replace the two court-ordered projects, the SVSP 72-Bed EOP-ASU project and the SVSP 96-Bed EOP-GP Treatment and Office Space and Housing Unit Conversion Project, with one project identified as the SVSP 300 EOP-GP Treatment and Office Space A-Quad Project is GRANTED. Pltfs' request for evidentiary hearing is DENIED. (Engbretson, K.) (Entered: 01/04/2010)
		* * * *
1/8/2010	3764	DECLARATION of Amy Whelan in Opposition to Defendants' Request for Temporary Relief Regarding the 256 Intermediate Care Facility Beds at Atascadero State Hospital 3760 MOTION. (Whelan, Amy) (Entered: 01/08/2010)
		* * * *

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01/27/2010	3787	ORDER granting in part and denying in part defendants' December 31, 2009 MOTION 3760 signed by Senior Judge Lawrence K. Karlton on 1/27/10: Status Conference set for 3/29/2010 at 11:00 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (Kaminski, H) .Modified on 1/29/2010 (Kaminski, H). (Entered: 01/27/2010)
		* * * *
02/03/2010	3794	RESPONSE by Schwarzenegger to 3761 Order. (Attachments: # 1 Exhibit A) (Ramsey, Samantha) (Entered: 02/03/2010)
		* * * *
2/12/2010	3799	ORDER signed by Senior Judge Lawrence K. Karlton on 2/12/10 ORDERING that Defendants' 2/1/10 request for temporary relief from this court's 1/4/10 order requiring them to file an amended plan for the Stark EOP conversation project is granted; Defendants are granted 90 days to file an amended bed plan for the EOP population targeted for the Stark facility; Defendants' motion for reconsideration of this court's 1/4/10 order requiring them to file an amended plan for the Stark EOP conversion project is dropped from calendar. Within 90 days from the

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		date of this order defendants shall either renotice said motion for hearing on this court's regular law and motion calendar pursuant to the provisions of Local Rule 230 or file a notice withdrawing said motion. This court's 1/4/10 order requiring defendants to submit a new activation schedule for the proposed DeWitt conversion project is stayed pending resolution of defendants' motion for reconsideration of said order; and Defendants' motion for reconsideration of this court's 1/4/10 order requiring defendants to submit a new activation schedule for the proposed DeWitt conversion project is reset to 3/29/10 at 11:00 a.m; (Becknal, R) (Entered: 02/12/2010)
		* * * *
02/25/2010	3811	STIPULATION and ORDER 3810 signed by Senior Judge Lawrence K. Karlton on 2/25/2010 re: Modification of defendants' Short-Term Project for 150 Level III/IV Enhanced Outpatient Program sensitive needs yard beds at Substance Abuse Treatment Facility. (Marciel, M) (Entered: 02/25/2010)
		* * * *
3/24/2010	3823	ORDER defendants have requested a withdrawal 3821 of their 3791

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		Motion for Reconsideration and requested 7 days to submit their DeWitt activation schedule. The court GRANTS defendants' request for an additional 7 days. The hearing on the motion for reconsideration is VACATED. Defendants shall submit within 7 days of this order the DeWitt activation schedule required by the court's 1/4/2010 order. Status conference set by the 1/27/10 order remains on calendar. Signed by Senior Judge Lawrence K. Karlton on 03/24/2010. (Holland, K) (Entered: 03/24/2010)
		* * * *
03/26/2010	3828	STATUS REPORT by Schwarzenegger. (Attachments: # 1 Declaration of D. Vorous, # 2 Declaration of C. Radavsky, # 3 Declaration of R. Johnson, # 4 Declaration of L. McGill) (Vorous, Debbie) Modified on 3/29/2010 (Yin, K). (Entered: 03/26/2010)
		* * * *
03/30/2010	3830	RESPONSE by Schwarzenegger to 3823 Order on Motion for Reconsideration, and Order on Motion to Stay 3761. (Vorous, Debbie) Modified on 3/31/2010 (Plummer, M). (Entered: 03/30/2010)

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03/31/2010	3831	ORDER signed by Senior Judge Lawrence K. Karlton on 3/30/10 ORDERING that the special master shall monitor defts' implementation of their policies and practices regarding referral and transfer of Coleman class members in inpatient care; within 90 days defts shall work together to develop a plan to reduce or eliminate the wait lists for inpatient care and better serve the treatment needs of Coleman class members; plan shall be filed with the court within 120 days from the date of this order. (Owen, K) (Entered: 03/31/2010)
		* * * *
04/14/2010	3836	ORDER signed by Senior Judge Lawrence K. Karlton on 4/14/2010 ORDERING that the 3758 Special Master's Recommendations are not adopted at this time. Over the next 120 days, dfts shall review all suicide prevention policies and practices, all suicide review and reporting processes, and the implementation of such policies, practices and processes. Within 45 days thereafter the special master shall report to the court on the foregoing review. DMH Dfts shall meet and confer with the special master concerning production of informa-

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		tion essential to the special master's suicide review process and shall develop, if necessary, appropriate policies and procedures for such production. This shall take place within the 120 day review period set by this order. (Engbretson, K.) (Entered: 04/14/2010)
		* * * *
05/13/2010	3845	RESPONSE by Schwarzenegger to 3799 Order. (Attachments: # 1 Exhibit) (Gomez, Gregory) (Entered: 05/13/2010)
		* * * *
05/14/2010	3847	AMENDED Defs' NOTICE of renewal of motion for reconsideration and Relief 3793 by Schwarzenegger. Motion Hearing set for 6/21/2010 at 10:00 AM in Courtroom 4 (LKK) before Senior Judge Lawrence K. Karlton. (Gomez, Gregory) Modified on 5/17/2010 (Plummer, M). (Entered: 05/14/2010)
		* * * *
06/04/2010	3853	RESPONSE by Ralph Coleman to 3793 MOTION for RECONSIDERATION *and Relief Re: The Stark Conversion Project; Memorandum of Points and Authorities.* (Bien, Michael) (Entered: 06/04/2010)

Date Filed	#	DOCKET TEXT
06/04/2010	3854	DECLARATION of MARK R FEESER in re 3793 MOTION for RECONSIDERATION *and Relief Re: The Stark Conversion Project; Memorandum of Points and Authorities.* (Feeser, Mark) (Entered: 06/04/2010)
06/14/2010	3855	REPLY by defendants to plaintiffs' 3853 Response to Motion for Reconsideration and Relief re Stark Conversion Project. (Vorous, Debbie) Modified on 6/15/2010 (Marciel, M). (Entered: 06/14/2010)
06/15/2010	3856	ORDER signed by Senior Judge Lawrence K. Karlton on 06/15/10 ORDERING that dfts' 3793 Motion for Reconsideration is DROPPED from the calendar; w/i 15 days dfts shall file a detailed statement identifying every step that might be taken to accelerate the project at each and every stage thereof. Defendants shall identify all actions required to accomplish such steps, including but not limited to waivers of state law, and shall identify the amount of time that can be saved by each step. (Benson, A.) (Entered: 06/15/2010)

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Date Filed	#	DOCKET TEXT
06/21/2010	3865	STIPULATION and ORDER signed by Senior Judge Lawrence K.

Date Filed	#	DOCKET TEXT
		Karlton on 6/18/10 ORDERING dfts to replace the 150-bed Level III/IV EOP-GP project at SOL with the intermediate-term project described in this order for 150-bed Levin IV EOP-SNY beds at RJD. (Carlos, K) (Entered: 06/21/2010)
06/21/2010	3866	STIPULATION and ORDER signed by Senior Judge Lawrence K. Karlton on 6/21/10 re MODIFICATION OF FULL OCCUPANCY DATES FOR 88-BED LEVEL I/II and WAIVER OF CALIFORNIA CODE OF REGULATIONS, TITLE 15, SECTIONS 3040.1(a) and (c)(6). (Kaminski, H) (Entered: 06/21/2010)
		* * * *
6/30/2010	3870	RESPONSE by Schwarzenegger to [3856] Order. (Attachments: # (1) Declaration [Declaration) (Vorous, Debbie) Modified on 7/1/2010 (Plummer, M).
		* * * *
07/21/2010	3885	NOTICE *[Defs' Update to Court re: Use of "Design-Build" Authority for the New Construction Projects Identified in Defs' Amended Long-Range Mental Health Bed Plan for the Stark Facility]* by Schwarzenegger. (Vorous, Debbie)
		* * * *

Date Filed	#	DOCKET TEXT
8/4/2010	3894	STIPULATION and ORDER signed by Senior Judge Lawrence K. Karlton on 8/4/10 ORDERING that Defendant shall have a one hundred twenty day extension of time up to and including 11/26/2010, to develop and file with the Court their plan to reduce or eliminate the wait lists for inpatient care and, in the interim, to better serve the tratment needs of Coleman class members placed on such lists. (Mena-Sanchez, L) (Entered: 08/04/2010)
		* * * *
08/30/2010	3904	NOTICE (Update to Court) *Re: Dfts' Amended Long-Range Mental Health Bed Plan for the Stark Facility* in response to [3856] Order by Schwarzenegger. (Vorous, Debbie) Modified on 9/2/2010 (Yin, K).
		* * * *
9/27/2010	3918	SPECIAL MASTER'S REPORT by Matthew A Lopes, Jr. on review of suicide prevention policies, practices and procedures. (Attachments: # 1 Exhibit A, # 2 Exhibit A-1, # 3 Exhibit A-2, # 4 Exhibit A-3, # 5 Exhibit B, # 6 Exhibit C, # 7 Exhibit D, # 8 Exhibit E, # 9 Exhibit F, # 10 Exhibit G, # 11 Exhibit H) (Lopes, Matthew) Modified on 9/28/2010 (Marciel, M). (Entered: 09/27/2010)

Date Filed	#	DOCKET TEXT
		* * * *
10/4/2010	3930	MINUTES for proceedings held before Senior Judge Lawrence K. Karlton: EVIDENTIARY HEARING re 3907 held on 10/4/2010. Witnesses: William Westin, Victor Brewer, Jean Barawed, John Guhl. Court order to issue. Plaintiffs Counsel Michael Bien, Jane Kahn, Amy Whelan present. Defendants Counsel Debbie Vorous present. Court Reporter: C. Bodene. (Rivas, A) (Entered: 10/05/2010)
10/5/2010	3929	ORDER signed by Senior Judge Lawrence K. Karlton on 10/5/10: Defendants shall complete permanent replacement of the fire suppression system in C-6 and gain occupancy of that unit from the State Fire Marshal not later than November 19, 2010, and shall complete permanent replacement of the fire suppression system in C-5 and gain occupancy of that unit from the State Fire Marshal not later than January 14, 2011. Beginning on October 12, 2010, defendants shall admit inmate patients to the C-5 Unit at a rate of not less than ten inmate patients per week until that unit is filled. Following the transfer of inmate patients from the C-5 Unit to the C-6 Unit

Date Filed	#	DOCKET TEXT
		and completion of the permanent replacement of the fire suppression system, defendants shall begin admitting inmate patients to the C-5 Unit on January 18, 2011 and shall admit inmate patients to that unit at a rate of not less than ten inmate patients per week until both the C-5 and C-6 Units are filled. The court intends to waive the provisions of state law referred to in the testimony of Victor Brewer to the extent required to comply with paragraphs 2 and 3 of this order. Within five days from the date of this order, defendants shall file a statement identifying those provisions of state law. Within seven days from the date of this order, CDCR and DMH defendants shall meet with the special master to develop a review program modeled on the DMH-ICF Pilot Program for evaluation of inmates presently housed in Level IV inpatient hospital facilities to determine whether any of those inmates can be transferred to another ICF facility. Within sixty days thereafter defendants shall complete the review and evaluation of inmates in Level IV DMH inpatient hospital facilities and shall report to the special master on the outcome of

Date Filed	#	DOCKET TEXT
		those evaluations. (Kaminski, H) (Entered: 10/05/2010)
		* * * *
10/12/2010	3932	MOTION for Relief re The Courts 3929 Order by Schwarzenegger. (Attachments: # 1 Declaration of V. Brewer, # 2 Declaration of R. Lipon) (Vorous, Debbie) Modified on 10/18/2010 (Yin, K). (Entered: 10/12/2010)
10/12/2010	3933	MOTION to STAY (Request) Pending The Courts Disposition Of Defendants 3932 Motion For Relief Re: The Courts 10/5/10 Order by Schwarzenegger. (Vorous, Debbie) Modified on 10/18/2010 (Yin, K). (Entered: 10/12/2010)
10/13/2010	3934	ORDER signed by Senior Judge Lawrence K. Karlton on 10/13/2010 ORDERING 3933 Defendants' 3932 Request for stay pending disposition of their motion for relief from part of this court's 10/5/2010 order is GRANTED; dfts are relieved of the obligation to comply with paragraph 2 of this court's 10/5/2010 order pending further order of the court; Within 7 days from the date of this order pltfs shall file and serve a response to dfts' motion for relief from certain provisions of the court's 10/5/2010 order; and Upon

Date Filed	#	DOCKET TEXT
		the filing of pltf's response, the court will either resolve dfts' motion for relief on the papers or set the matter for further hearing. (Reader, L) (Entered: 10/13/2010)
		* * * *
10/19/2010	3941	STATUS REPORT by Schwarzenegger. (Attachments: # 1 Declaration) (Vorous, Debbie) (Entered: 10/19/2010)
		* * * *

U.S. District Court
California Northern District (San Francisco)

CIVIL DOCKET FOR CASE #: 3:01-cv-01351-THE
Date Filed 04-05-2001

PLATA et al.

v

SCHWARZENEGGER et al.

RELEVANT DOCKET ENTRIES

Date Filed	Plata # / [Coleman #][1]	Docket Text
04/05/2001	1	COMPLAINT *;class action* against all defendants (Filing fee $150 receipt number 3320893). Filed by Gilbert Aviles, Steven Bautista, Paul Decasas, Joseph Long, Marciano Plata, Leslie Rhoades, Otis Shaw, Ray Stoderd. (aaa,) (Entered: 04/10/2001)

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[1] Submissions to and orders issued by the three-judge district court generally were docketed by both the *Plata* (N.D. Cal.) and the *Coleman* (E.D. Cal.) district courts. To avoid unnecessary duplication in the joint appendix, however, such three-judge court materials appear only in the "Relevant Docket Entries" section pertinent to *Plata*. In doing so, this section of the joint appendix also indicates the parallel locations on the *Coleman* docket where the same three-judge court materials can be found.

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
08/20/2001	20	AMENDED COMPLAINT , *First* against all defendants. Filed by Gilbert Aviles, Steven Bautista, Paul Decasas, Raymond Johns, Joseph Long, Marciano Plata, Leslie Rhoades, pro se Elijah J. Sandoval, Otis Shaw, pro se Gary Alan Smith, Ray Stoderd. (rbe,) (Entered: 08/22/ 2001)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/13/2002	67	ORDER appointing experts pursuant to Rule 706. Signed by Judge Thelton E. Henderson on 6/13/02. (rbe) (Entered: 06/19/2002)
06/13/2002	68	STIPULATION AND ORDER for injunctive relief. Signed by Judge Thelton E. Henderson on 6/13/02. (rbe) (Entered: 06/19/2002)
06/20/2002	69	ORDER adopting class action stipulation as fair, reasonable and adequate. Signed by Judge Thelton E.

Date Filed	Plata # / [Coleman #]	Docket Text
		Henderson on 6/20/02. (rbe) (Entered: 06/26/2002)
		* * * *
07/30/2003	159	ORDER re paragraph 7; see document for details. Signed by Judge Thelton E. Henderson on 7/29/03. (rbe) (Entered: 07/31/2003)
		* * * *
08/13/2003	161	ORDER by Judge Thelton E. Henderson granting in part and denying in part 143 Motion to Compel (rbe) (Entered: 08/15/2003)
		* * * *
01/28/2004	184	ORDER of USCA Stipuation that the parties agree that the circuit clerk may dismiss the aove entitled appeal 03 17276. Plaintiffs and Appellees fees and costs shall be paid by defendants-Appellants in the manner set forth in the stipulation and order in the USDC. (db, COURT STAFF) (Filed on 1/28/2004) (Entered: 01/28/2004)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
04/20/2004	199	STIPULATION AND ORDER regarding the production and access to documents and other information. Signed by Judge Thelton E. Henderson on 4-20-04. (db, COURT STAFF) (Filed on 4/20/2004) (Entered: 04/20/2004)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/10/2004	220	Letter from For the Experts, Michael Puisis et al. to the Court reporting on CDC adherence to stipulation paragraph 6b specifically the inter-institutional transfer protocol etc. (db, COURT STAFF) (Filed on 8/10/2004) (Entered: 08/13/2004)
08/10/2004	221	Letter from Court Experts to the court re Credentialing and Physician Qualifications. (db, COURT STAFF) (Filed on 8/10/2004) (Entered: 08/13/2004)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/17/2004	229	STIPULATION AND ORDER regarding Quality of Patient Care and Staffing.. Signed by Judge Thelton E. Henderson on 9/17/04. (db, COURT STAFF) (Filed on 9/17/2004) (Entered: 09/21/2004)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/17/2004	255	Letter from Michael Puisis, D.O. of the Office of the Medical Experts to the Court re expert's report on CDC General Acute Care Hospitals and skilled nursing needs in those facilities. (db, COURT STAFF) (Filed on 11/17/ 2004) (Entered: 11/18/2004)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/16/2005	282	STIPULATED ORDER re modification of stipulation for injunctive relief filed 6/13/02 68 (db, COURT STAFF) (Filed on 2/16/2005) (Entered: 02/17/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/10/2005	294	ORDER TO SHOW CAUSE re Civil Contempt and Appointment of Interim Receiver Order to Show Cause Hearing set for 7/11/2005 10:00 AM.Any response by defendants to this Order to Show Cause must be filed and served by 6/22/05: plaintiffs shall have until 7/6/05 to fle and serve a reply to defendants' submission.. Signed by Judge Thelton E. Henderson on 5/10/05. (db, COURT STAFF) (Filed on 5/10/2005) (Entered: 05/10/2005)
05/10/2005	295	Letter from Plata Medical Experts, Joe Goldenson, M.D. to the Court, this report provides a summary of the site visit conducted by Jackie Clark, RN, and myself at San Quentin on 2/7-8-05. (db, COURT STAFF) (Filed on 5/10/2005) (Entered: 05/10/2005)
05/10/2005	296	Received Document from the Office of the Medical Experts, Medical Experts Report on San Quentin April 8,

Date Filed	Plata # / [Coleman #]	Docket Text
		2005.. (db, COURT STAFF) (Filed on 5/10/2005) (Entered: 05/10/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/19/2005	300	Received Document: Expert Report re CSP-Corcoran site visit. (db, COURT STAFF) (Filed on 5/19/2005) (Entered: 05/20/2005)
05/19/2005	301	Received Document: Expert Report re: Substance abuse treatment center site visit. (db, COURT STAFF) (Filed on 5/19/2005) (Entered: 05/20/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/25/2005	304	JOINT PREHEARING STATEMENT filed by plaintiffs(db, COURT STAFF) (Filed on 5/25/2005) (Entered: 05/26/2005)
05/31/2005	305	Minute Entry: Evidentiary Hearing held on 5/31/2005 before Thelton E. Henderson (Date Filed: 5/31/2005). Evidentiary Hearing reset for 6/1/2005 08:30 AM. (Court Reporter Sahar McVickar.)

Date Filed	Plata # / [Coleman #]	Docket Text
		(db, COURT STAFF) (Date Filed: 5/31/2005) (Entered: 06/01/2005)
06/01/2005	306	Ex Parte Application for appointment of temporary receiver filed by plaintiffs(db, COURT STAFF) (Filed on 6/1/2005) (Entered: 06/01/2005)
06/01/2005	307	Minute Entry: Evidentiary Hearing held on 6/1/2005 before Thelton E. Henderson (Date Filed: 6/1/2005). Evidentiary Hearing set for 6/2/2005 08:30 AM. (Court Reporter Sahar McVickar.)Summary: Madeleine LaMarre testified: Joe Goldenson began testimony. (db, COURT STAFF) (Date Filed: 6/1/2005) (Entered: 06/01/ 2005)
06/02/2005	308	Minute Entry: Evidentiary Hearing held on 6/2/2005 before Thelton E. Henderson (Date Filed: 6/2/2005). Evidentiary Hearing reset for 6/7/2005 08:30 AM. (Court Reporter Sahar McVickar.)Summary: Joe Goldenson

Date Filed	Plata # / [Coleman #]	Docket Text
		finished testimony. Brigid Hanson, Sandra Duveneck and Jeff Baldo testified. (db, COURT STAFF) (Date Filed: 6/2/2005) (Entered: 06/03/2005)
06/07/2005	309	Minute Entry: Evidentiary Hearing held on 6/7/2005 before Thelton E. Henderson (Date Filed: 6/7/2005). Evidentiary Hearing reset for 6/8/2005 08:30 AM. (Court Reporter Sahar McVickar.)Summary: Bob Horel, Kevin Carruth and Renee Kanan testified. Defendant's post-hearing brief is due 6/20/05: Plaintiff's post - hearing brief is due 6/27/05: hearing is set for 6/30/05 at 9:00 AM (db, COURT STAFF) (Date Filed: 6/7/2005) (Entered: 06/08/2005)
06/08/2005	310	EXHIBIT from evidentiary hearing, 5 envelopes, Under Seal, in the Trial Exhibit Room. (db, COURT STAFF) (Filed on 6/8/2005) Modified on 6/8/2005 (db, COURT STAFF).Bin #19 (Entered: 06/08/2005)

Date Filed	Plata # / [Coleman #]	Docket Text
06/08/2005	311	Minute Entry: Evidentiary Hearing held on 6/8/2005 before Thelton E. Henderson (Date Filed: 6/8/2005) and concluded (Day 5). Summary: Ronald Shansky and Tim Rougeux testified. Exhibits #1-65, #67-89 and #97-98 are admitted. Objections to exhibits #66 and #90-96 are taen under submission. The Court set a 35-page limit on the post-trial briefs for both parties. (Court Reporter Sahar McVickar.) (db, COURT STAFF) (Date Filed: 6/8/ 2005) (Entered: 06/08/2005)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
06/20/2005	328	Response to Order To Show Cause re civil contempt and appointment of interim receiver and opposition to plaintiffs ex parte request for appointment of temporary receiver. filed bydefendants (db, COURT STAFF) (Filed on 6/20/2005) (Entered: 06/21/2005)

Date Filed	Plata # / [Coleman #]	Docket Text
06/20/2005	329	Declaration of Renee Kanan, M.D. in Support of 328 Reply Memorandum filed byB. Timothy Gage. (Related document(s) 328) (db, COURT STAFF) (Filed on 6/20/2005) (Entered: 06/21/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/27/2005	334	Response to order to show cause re civil contempt and appointment of interim receiver and reply to defendants opposition to plaintiffs' exparte request for appointment of temporary receiver filed by plaintiffs. (db, COURT STAFF) (Filed on 6/27/2005) Modified on 6/28/2005 (db, COURT STAFF). (Entered: 06/28/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/30/2005	338	Minute Entry: Show Cause Hearing held (Date Filed: 6/30/2005). (Court Reporter Rosita Flores.)Court to prepare order. Summary: Closing arguments from the evidentiary hearing made. This Court's opinion read in

Date Filed	Plata # / [Coleman #]	Docket Text
		Court. (db, COURT STAFF) (Date Filed: 6/30/2005) (Entered: 07/01/2005)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
10/03/2005	371	FINDINGS OF FACT AND CONCLUSIONS OF LAW re Appointment of Receiver. Signed by Judge Thelton E. Henderson on 10/3/05. (rcs, COURT STAFF) (Filed on 10/3/2005) (Entered: 10/05/2005)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
10/03/2005	374	ORDER Appointing John Hagar as Court Expert. Signed by Judge Thelton E. Henderson on 10/3/05. (rcs, COURT STAFF) (Filed on 10/3/2005) (Entered: 10/05/2005)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
10/11/2005	379	ORDER Signed by Judge Thelton E. Henderson on 10/11/05 that Dr. Terry Hill is Appointed as a Medical Expert for the purpose of assisting the Correctional Expert with respect to the fol-

Date Filed	Plata # / [Coleman #]	Docket Text
		lowing issue: the need to provide critical staff, including physicians, mid-level providers, and nursing personnel as those California Department of Corrections & Rehabilitation ("CDCR") institutions with the greatest immediate need. Dr. Hill shall be compensated at the same hourly rate ($300.00 per hour) that he is compensated for with respect to his work as an expert in Madrid v. Gomez, C-90-3094.(tn, COURT STAFF) (Filed on 10/11/2005) (Entered: 10/11/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/25/2005	395	CORRECTIONAL EXPERT'S INITIAL REPORT Filed by Special Master John Hagar, Esq.. (tn, COURT STAFF) (Filed on 10/25/ 2005) (Entered: 10/25/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/14/2005	404	CORRECTIONAL EXPERT'S REPORT re Clinical Staffing Filed by Correction-

Date Filed	Plata # / [Coleman #]	Docket Text
		al Expert John Hagar. (tn, COURT STAFF) (Filed on 11/14/2005) (Entered: 11/16/2005)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
11/28/2005	415	CIVIL MINUTES ENTRY: [Court Reporter: Juanita Gonzalez) Hearing Regarding Correctional Expert's Report -- Held before Judge Henderson. Order to be prepared by the Court. (tn, COURT STAFF) (Date Filed: 11/28/2005) (Entered: 11/29/2005)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/01/2005	419	ORDER Signed by Judge Thelton E. Henderson on 12/1/05 re Interim Remedies Relating to Clinical Staffing. (tn, COURT STAFF) (Filed on 12/1/2005) (Entered: 12/02/2005)
12/01/2005	420	ORDER Re Interim Remedies Relating to Clinical Staffing (electronic version of docket # 419). Signed by Judge Thelton E. Henderson on 12-1--05. (tehlc1, COURT

Date Filed	Plata # / [Coleman #]	Docket Text
		STAFF) (Filed on 12/1/2005) (Entered: 12/07/2005)
		* * * *
12/08/2005	429	DESIGNATION of Dr. Peter Farber-Szekrenyi Pursuant to the Order re Interim Remedies Relating to Clinical Staffing. Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 12/8/2005) (Entered: 12/09/2005)
		* * * *
12/15/2005	434	DECLARATION of Dr. Peter Farber-Szekrenyi re Status Report & Compliance with Order re Interim Remedies Relating to Clinical Staffing. Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 12/15/2005) (Entered: 12/16/2005)
12/15/2005	435	CORRECTIONAL EXPERT REPORT re Monitoring of Court's Order of December 2, 2005 Filed by Special Master/Correctional Expert John Hagar. (tn, COURT

Date Filed	Plata # / [Coleman #]	Docket Text
		STAFF) (Filed on 12/15/2005) (Entered: 12/16/2005)
		* * * *
12/19/2005	437	DECLARATION of Dr. Peter Farber-Szerkrenyi re December 19, 2005 Status Report & Compliance with Order re Interim Remedies Relating to Clinical Staffing. Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 12/19/2005) (Entered: 12/20/2005)
		* * * *
12/22/2005	446	DECLARATION of Dr. Peter Farber-Szekrenyi re December 22, 2005 Status Report & Compliance with Order re Interim Remedies Relating to Clinical Staffing. Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 12/22/2005) (Entered: 12/22/2005)
12/30/2005	447	DECLARATION of Dr. Peter Farber-Szekrenyi re December 30, 2005 Status Report

Date Filed	Plata # / [Coleman #]	Docket Text
		& Compliance with Order re Interim Remedies Relating to Clinical Staffing. Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 12/30/2005) (Entered: 01/03/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/03/2006	449	REPORT re California Department of Corrections & Rehabilitation Death Reviews Filed by John Hagar, Special Master/Correctional Expert. (tn, COURT STAFF) (Filed on 1/3/2006) (Entered: 01/04/2006)
01/03/2006	450	ORDER Signed by Judge Thelton E. Henderson on 12/22/05 APPOINTING Dr. David Lawrence as an Expert for the Purpose of Assisting the Court with the Receivership process in this case.(tn, COURT STAFF) (Filed on 1/3/2006) (Entered: 01/04/2006)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
01/17/2006	460	STIPULATION AND ORDER Signed by Judge Thel-

Date Filed	Plata # / [Coleman #]	Docket Text
		ton E. Henderson on 1/17/2006 Regarding Program to Monitor the Healthcare Services Provided by CMG/MHA/STAFF CARE. (tn, COURT STAFF) (Filed on 1/17/2006) (Entered: 01/18/2006)
01/17/2006	461	DECLARATION of Dr. Peter Farber-Szekrenyi re January 17, 2006 Status Report & Compliance with Order re Interim Remedies Relating to Clinical Staffing Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 1/17/2006) (Entered: 01/18/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/14/2006	473	ORDER APPOINTING RECEIVER. Signed by Judge Thelton E. Henderson on 2-14-06. (tehlc1, COURT STAFF) (Filed on 2/14/2006) (Entered: 02/14/2006)
02/22/2006	474	ORDER Signed by Judge Thelton E. Henderson on 2/22/2006 that the Court's Correctional Expert, John Hagar shall: (1) undertake,

Date Filed	Plata # / [Coleman #]	Docket Text
		in consultation with the Receiver, such tasks as may be necessary for the preliminary establishment of the Office of the Receiver, and (2) investigate & report to the Receiver concerning the status of (a)State contracts relating to health care services, (b)State contract negotiations relating to health care services, and (c) contractual payments to service providers (clinicians & medical facilities) who provide health care services to CDCR inmate/patients. These duties shall be in addition to those duties set forth in the Order Appointing Court Expert, dated 10/3/2005. (tn, COURT STAFF) (Filed on 2/22/2006) (Entered: 02/23/ 2006)
	* * * *	
02/28/2006	476	DECLARATION of Dr. Peter Farber-Szekrenyi re February 28, 2006 Status Report & Compliance with Order Re Interim Remedies Relating to Clinical Staffing Filed by

Date Filed	Plata # / [Coleman #]	Docket Text
		Defendants Arnold Schwarzenegger, et al. (tn, COURT STAFF) (Filed on 2/28/2006) (Entered: 03/01/2006)

* * * *

03/15/2006	484	DECLARATION of Counsel Jonathan L. Wolff in Compliance with Paragraph VI of Court's Order Appointing Receiver Filed by Defendats Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 3/15/2006) (Entered: 03/17/2006)
03/16/2006	485	DECLARATION of Jeanne Woodford re Compliance with Order Appointing Receiver Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 3/16/2006) (Entered: 03/17/2006)

* * * *

03/27/2006	489	CORRECTIONAL EXPERT'S REPORT Re Status of State Contracts & Contract Payments Relating to Service Providers for CDCR Inmate/Patients Filed by

Date Filed	Plata # / [Coleman #]	Docket Text
		Special Master John Hagar. (tn, COURT STAFF) (Filed on 3/27/2006) (Entered: 03/27/2006)
03/30/2006	490	ORDER Signed by Judge Thelton E. Henderson on 3/30/2006 Re State Contracts & Contract Payments Relating to Service Providers for CDCR Inmate/ Patients.(tn, COURT STAFF) (Filed on 3/30/2006) (Entered: 04/03/ 2006)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
04/12/2006	499	ORDER Signed by Judge Thelton E. Henderson on 4/12/2006 that the Clerk of the Court shall issue a Check, payable to Robert Sillen, Receiver, in the amount of $50,000 from the Plaza Initial Operating Fund Account containing $750,000. The Receiver shall immediately deposit said check into a newly-opened bank account to be used exclusively for costs associated with the initial start-up of the Office of Receiver (e.g. pay-

Date Filed	Plata # / [Coleman #]	Docket Text
		ment for telephones, computers, etc.). Once the $50,000 is expended for these purposes, the account shall be closed. The Inspector General shall of course have full access to any and all records pertaining to this account. (tn, COURT STAFF) (Filed on 4/12/2006) (Entered: 04/12/ 2006)
		* * * *
04/14/2006	501	ORDER Signed by Judge Thelton E. Henderson on 4/13/2006 that in order to facilitate the efficient coordination of this action with Coleman v. Schwarzenegger, C S-90-020 LKK, this matter is set for a joint hearing in Plaza & Coleman to be held before the undersigned and the Honorable Lawrence K. Karlton on June 8, 2006 at 10:00 a.m. in Courtroom 4, Robert T. Matsui United States Courthouse, 501 "I" Street, Sacramento, California 95814. (tn, COURT STAFF) (Filed on 4/14/2006) (Entered: 04/19/2006)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
07/05/2006	524	RECEIVER'S FIRST BI-MONTHLY REPORT Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 7/5/2006) (Entered: 07/06/2006)
07/05/2006	525	APPENDIX of Exhibits to Receiver's First Bi-Monthly Report re 524 Filed by Receiver Robert Sillen. (Related document(s) 524). (tn, COURT STAFF) (Filed on 7/5/2006) (Entered: 07/06/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/12/2006	543	MOTION for a Waiver of State Law Filed by Receiver Robert Sillen.. (tn, COURT STAFF) (Filed on 9/12/2006) (Entered: 09/14/2006)
09/12/2006	544	APPENDIX OF EXHIBITS Supporting re 543 MOTION for a Waiver of State Law Filed by Receiver Robert Sillen. (Related document(s) 543). (tn, COURT STAFF)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 9/12/2006) (Entered: 09/14/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/19/2006	547	SECOND BI-MONTHLY REPORT Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 9/19/2006) (Entered: 09/21/2006)
09/19/2006	548	APPENDIX OF EXHIBITS in Support of re 547 Second Bi-Monthly Report Fled by Receiver Robert Sillen. (Related document(s) 547). (tn, COURT STAFF) (Filed on 9/19/2006) (Entered: 09/21/2006)
09/20/2006	549	APPENDIX OF PHOTOGRAPHS in Support of re 547 Second Bi-Monthly Report Filed by Receiver Robert Sillen. (Related document(s) 547). (tn, COURT STAFF) (Filed on 9/20/2006) (Entered: 09/21/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/26/2006	551	RESPONSE to Receiver's re 543 MOTION for a Waiver of State Law Filed by Plain-

Date Filed	Plata # / [Coleman #]	Docket Text
		tiffs. (tn, COURT STAFF) (Filed on 9/26/2006) (Entered: 09/27/2006)
09/26/2006	552	RESPONSE to Receiver's re 543 MOTION for a Waiver of State Law Filed by Defendants. (tn, COURT STAFF) (Filed on 9/26/2006) (Entered: 09/27/2006)
* * * *		
10/17/2006	554	ORDER Signed by Judge Thelton E. Henderson on 10/17/2006 Regarding Receiver's Motion for a Waiver of State Law. (tn, COURT STAFF) (Filed on 10/17/2006) (Entered: 10/18/2006)
* * * *		
11/08/2006	557	ORDER Signed by Judge Thelton E. Henderson on 11/8/2006 Regarding State Contracts. (tn, COURT STAFF) (Filed on 11/8/2006) (Entered: 11/08/2006)
* * * *		
11/13/2006	559	MOTION for an Extension of Time to File Plan of Action

Date Filed	Plata # / [Coleman #]	Docket Text
		& Establish Advisory Board; MOTION to Modify Provision of June 13, 2002 Stipulation Re Injunctive Relief Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 11/13/2006) (Entered: 11/14/2006)
		* * * *
11/13/2006	561	NOTICE OF MOTION & MOTION to Convene a Three Judge Panel to Limit Prison Population Filed by Plaintiffs Raymond Johns, Otis Shaw, Elijah J. Sandoval, Gary Alan Smith, Ray Stoderd, Clifford Myelle, Joseph Long, Marciano Plata, Leslie Rhoades, Gilbert Aviles, Paul Decasas & Steven Bautista. (tn, COURT STAFF) (Filed on 11/13/2006) (Entered: 11/14/2006)
11/13/2006	562	DECLARATION of Brittany Glidden in Support of re 561 MOTION to Convene a Three Judge Panel to Limit Prison Population Filed by Plaintiffs Raymond Johns, Otis Shaw, Elijah J. San-

Date Filed	Plata # / [Coleman #]	Docket Text
		doval, Gary Alan Smith, Ray Stoderd, Clifford Myelle, Joseph Long, Marciano Plata, Leslie Rhoades, Gilbert Aviles, Paul Decasas & Steven Bautista. (Related document(s) 561). (tn, COURT STAFF) (Filed on 11/13/2006) (Entered: 11/14/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/16/2006	564	ORDER Signed by Judge Thelton E. Henderson on 11/16/2006 that the parties shall have until 12/1/2006 to file an opposition, statement of non-opposition or to otherwise respond and that the matter shall then be deemed submitted on the papers unless the Court orders otherwise. (tn, COURT STAFF) (Filed on 11/16/2006) (Entered: 11/17/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/04/2006	579	MEMORANDUM of Points & Authorities in Opposition to re 561 Plaintiffs' MOTION to Convene a Three Judge Panel to Limit Prison Population Filed by Defen-

Date Filed	Plata # / [Coleman #]	Docket Text
		dants Arnold Schwarzenegger, et al.. (Related document(s) 561). (tn, COURT STAFF) (Filed on 12/4/2006) (Entered: 12/05/ 2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/05/2006	581	THIRD BI-MONTHLY REPORT Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 12/5/2006) (Entered: 12/06/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/11/2006	586	AMICUS CURIAE BRIEF Filed by California Correctional Peace Officers' Association. (tn, COURT STAFF) (Filed on 12/11/2006) (Entered: 12/12/2006)
12/11/2006	587	REPLY to Opposition to Motion to Convene a Three-Judge Panel to Limit Prison Population Filed by Plaintiffs Marciano Plata, et al.. (tn, COURT STAFF) (Filed on 12/11/2006) (Entered: 12/12/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/19/2006	590	ORDER Signed by Judge Thelton E. Henderson on 12/19/06 that the first sentence of Section I (B) of the Court's February 14, 2006 Order Appointing Receiver shall be replaced & The Court grants the Receiver's request to modify, on a pilot basis as San Quentin Prison only, the process for screening & evaluating newly arriving inmates prescribed by the 6/13/2002 Stipulation, so that the process is consistent with the process described at page 18 of the Receiver's motion. (tn, COURT STAFF) (Filed on 12/19/2006) (Entered: 12/20/2006)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/08/2007	596	Minute Entry: Motion Hearing held on 1/8/2007 before Judge Thelton E. Henderson. The motion to convene a three-judge panel is taken under submission.(Court Reporter: Sahar McVickar) (rbe, COURT STAFF) (Date

Date Filed	Plata # / [Coleman #]	Docket Text
		Filed: 1/8/2007) (Entered: 01/08/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/10/2007	599	SUPPLEMENTAL BRIEF in Support of re 561 MOTION to Convene a Three-Judge Panel to Limit Prison Population Filed by Plaintiffs. (Related document(s) 561).(tn, COURT STAFF) (Filed on 1/10/2007) (Entered: 01/16/2007)
01/10/2007	600	SUPPLEMENTAL BRIEF in Opposition to re Plaintiffs' Motion to Convene a Three-Judge Panel to Limit Prison Population Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 1/10/2007) (Entered: 01/16/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/26/2007	603	ORDER Signed by Judge Thelton E. Henderson & Judge Jeffrey S. White on 1/25/2007 Regarding coordination of the remedial processes in cases C-05-5241-JSW & CIV-S-90-0520-

Date Filed	Plata # / [Coleman #]	Docket Text
		LKK JFM P (E.D.Cal.). (tn, COURT STAFF) (Filed on 1/26/2007) (Entered: 01/29/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/29/2007	605	REPORTER'S TRANSCRIPT of Proceedings Held on 1/8/2007 before Judge Thelton E. Henderson - [Court Reporter: Sahar McVickar]. (tn, COURT STAFF) (Filed on 1/29/2007) (Entered: 01/30/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/28/2007	610	APPLICATION for Order Nunc Pro Tunc Waiving State Contracting Statutes, Regulations & Procedures with Respect to Contract Awarded to Maxor National Pharmacy Services Corporation & Approving Receiver's Substitute Procedure for Bidding & Award of such Contract Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 2/28/2007) (Entered: 03/02/2007)

Date Filed	Plata # / [Coleman #]	Docket Text

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03/20/2007	618	FOURTH BI-MONTHLY REPORT Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 3/20/2007) (Entered: 03/21/2007)
03/20/2007	619	EXHIBITS to re 618 Fourth Bi-Monthly Report Filed by Receiver Robert Sillen.(Related document(s) 618). (tn, COURT STAFF) (Filed on 3/20/2007) (Entered: 03/21/2007)

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03/30/2007	621	ORDER Signed by Judge Thelton E. Henderson on 3/30/2007 Regarding Receiver's Application for Order Nunc Pro Tunc re 610 . (tn, COURT STAFF) (Filed on 3/30/2007) (Entered: 04/02/2007)

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04/06/2007	627	MOTION for One Time Limited Waiver of California Government Code Section 19080.3 Filed by Receiver

Date Filed	Plata # / [Coleman #]	Docket Text
		Robert Sillen. (tn, COURT STAFF) (Filed on 4/6/2007) (Entered: 04/10/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/17/2007	639	APPLICATION for Order Waiving State Contracting Statutes, Regulations & Procedures, and Approving Receiver's Substitute Procedure for Bidding & Award of Contracts. Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 4/17/2007) (Entered: 04/18/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/18/2007	642	AMENDED MOTION for Waiver of State Law Re Receiver Career Executive Assignments; Exhibits Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 4/18/2007) (Entered: 04/19/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/25/2007	645	MOTION for Waiver of State Law Re Physician Clinical Competency Determinations; Exhibits Filed by Re-

Date Filed	Plata # / [Coleman #]	Docket Text
		ceiver Robert Sillen. (tn, COURT STAFF) (Filed on 4/25/2007) (Entered: 04/26/2007)
04/25/2007	646	ORDER Signed by Judge Thelton E. Henderson on 4/24/2007 Regarding Receiver's Master Application for Order Waiving State Contracting Statutes, Regulations & Procedures. (tn, COURT STAFF) (Filed on 4/25/2007) (Entered: 04/26/2007)
04/25/2007	647	ORDER Signed by Judge Thelton E. Henderson on 4/24/2007 GRANTING re 627 Receiver's Motion for One Time Limited Waiver of California Government Code Section 19080.3 (tn, COURT STAFF) (Filed on 4/25/2007) (Entered: 04/26/2007)
05/01/2007	648	ORDER Signed by Judge Thelton E. Henderson on 5/1/2007 Setting Schedule re 645 Receiver's Motion for Waiver of State Law Re Physician Clinical Competency Determinations. (tn,

Date Filed	Plata # / [Coleman #]	Docket Text
		COURT STAFF) (Filed on 5/1/2007) (Entered: 05/02/2007)
		* * * *
05/09/2007	661	RESPONSE to re 642 Receiver's Amended MOTION for Waiver of State Law Re Receiver Career Executive Assignments; Exhibits Filed by California State Personnel Board. (tn, COURT STAFF) (Filed on 5/9/2007) (Entered: 05/10/2007)
		* * * *
05/10/2007	655	*NOTICE OF MOTION & RECEIVER'S MOTION for Order Modifying Stipulated Injunction & Other Orders Entered Herein* Filed by Receiver Robert Sillen. (Dodd, Martin) (Filed on 5/10/2007) (Entered: 05/10/2007)
05/10/2007	656	Declaration of John Hagar in Support of 655 Notice (Other) *Declaration of John Hager in Support of Receiver's Motion for Order Modifying Stipulated Injunction and Other Orders* filed by-

Date Filed	Plata # / [Coleman #]	Docket Text
		Robert Sillen. (Related document(s) 655) (Dodd, Martin) (Filed on 5/10/2007) (Entered: 05/10/2007)
05/10/2007	657	NOTICE by Robert Sillen *Receiver's Report re Plan of Action* (Dodd, Martin) (Filed on 5/10/2007) (Entered: 05/10/2007)
05/10/2007	658	NOTICE by Robert Sillen re 657 Notice (Other) *Notice of Filing of Receiver's Plan of Action* (Dodd, Martin) (Filed on 5/10/2007) (Entered: 05/10/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/15/2007	672	NOTICE of Filing of Receiver's "MAY REVISE" & California Prison Health Care Receivership Corporation Budget Filed by Receiver Robert Sillen. (tn, COURT STAFF) (Filed on 5/15/2007) (Entered: 05/17/2007)
05/15/2007	673	REPORT Re Overcrowding Filed by Receiver Robert Sillen. (tn, COURT STAFF)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 5/15/2007) (Entered: 05/17/2007)
05/15/2007	674	APPENDIX of EXHIBITS in Support of re 673 Report re Overcrowding Filed by Receiver Robert Sillen. (Related document(s) 673). (tn, COURT STAFF) (Filed on 5/15/2007) (Entered: 05/17/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/16/2007	667	*Defendants' REPORT In Response To The Court's February 15, 2007 Order* by B. Timothy Gage, Robert Presley, Arnold Schwarzenegger. (Tama, Samantha) (Filed on 5/16/2007) (Entered: 05/16/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/22/2007	682	Statement of Non-Opposition *Defendants' Statement of Non-Opposition to Receiver's Motion For Waiver of State Law Re Physician Clinical Competency Determinations* filed by B. Timothy Gage, Robert Presley, Arnold Schwarzenegger.

Date Filed	Plata # / [Coleman #]	Docket Text
		(Tama, Samantha) (Filed on 5/22/ 2007) (Entered: 05/22/ 2007)
05/22/2007	683	Statement of Non-Opposition *Statement of Non-Opposition to Receiver's Motion For Waiver of State Law Re PhysicianClinical Competency Determinations* filed by Marciano Plata. (Fama, Steven) (Filed on 5/22/2007) (Entered: 05/22/ 2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/25/2007	686	REPLY to Response to Motion *Receiver's Reply to Response of State Personnel Board To Master Application For Order Waiving State Contracting Statutes, Regulations and Procedures, etc.* filed by Robert Sillen. (Dodd, Martin) (Filed on 5/25/2007) (Entered: 05/25/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/25/2007	688	REPLY to Response to Motion *Receiver's Reply to Responses of Plaintiffs and State Personnel Board to Motion*

Date Filed	Plata # / [Coleman #]	Docket Text
		for Waiver of State Law re Receiver Career Executive Assignments filed by Robert Sillen. (Dodd, Martin) (Filed on 5/25/2007) (Entered: 05/25/2007)
05/25/2007	689	Declaration *of John Hagar in Support of Receiver's Motion for Waiver of State Law re Receiver Career Executive Assignments* filed by Robert Sillen. (Dodd, Martin) (Filed on 5/25/2007) (Entered: 05/25/2007)
05/29/2007	690	*SUPPLEMENTAL BRIEF in Opposition to Plaintiffs' Motion to Convene a Three-Judge Panel to Limit Prison Population; Defendants' Response to Receiver's Report Re Overcrowding* Filed by Defendants B. Timothy Gage, Robert Presley & Arnold Schwarzenegger. (Tama, Samantha) (Filed on 5/29/2007) (Entered: 05/29/2007)
05/29/2007	691	ORDER re agreements reached during coordination meetings. Signed by Judge

Date Filed	Plata # / [Coleman #]	Docket Text
		Thelton E. Henderson on 5/29/07. (tehlc1, COURT STAFF) (Filed on 5/29/2007) (Entered: 05/29/2007)
05/29/2007	692	REPLY to Response to Motion re 561 MOTION to Convene a Three Judge Panel to Limit Prison Population filed by Marciano Plata. (Norman, Sara) (Filed on 5/29/2007) (Entered: 05/29/2007)
05/29/2007	693	Declaration of Sara Norman in Support of 692 Reply to Response to Motion *to Convene Three-Judge Panel to Limit Prison Population* filed by Marciano Plata. (Attachments: # 1 # 2 # 3 # 4 # 5 # 6 # 7 # 8 # 9)(Related document(s) 692) (Norman, Sara) (Filed on 5/29/2007) (Entered: 05/29/2007)
05/29/2007	694	Declaration of James Austin in Support of 692 Reply to Response to Motion *to Convene Three-Judge Panel to Limit Prison Population* filed by Marciano Plata. (Related document(s) 692)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Norman, Sara) (Filed on 5/29/2007) (Entered: 05/29/2007)
05/30/2007	695	RESPONSE TO ORDER TO SHOW CAUSE by Marciano Plata. (Specter, Donald) (Filed on 5/30/2007) (Entered: 05/30/2007)
05/31/2007	696	NOTICE by Robert Sillen *Receiver's Request for Permission to File Motion to Implement Recommendations in Overcrowding Report and for Scheduling Order with Respect to Such Motion* (Dodd, Martin) (Filed on 5/31/2007) (Entered: 05/31/2007)
05/31/2007	697	Response to Order to Show Cause *re Joint Hearing on Motion to Convene Three Judge Panel to Limit Prison Population* by Ralph Coleman. (Bien, Michael) (Filed on 5/31/2007) (Entered: 05/31/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/04/2007	700	ORDER by Judge Thelton E. Henderson re 639 Receiver's

Date Filed	Plata # / [Coleman #]	Docket Text
		Master Application for Order Waiving State Contracting Statutes, Regulations, and Procedures, and Request for Approval of Substitute Procedures for Bidding and Award of Contracts (tehlc1, COURT STAFF) (Filed on 6/4/2007) (Entered: 06/04/2007)
06/04/2007	701	RESPONSE TO ORDER TO SHOW CAUSE by B. Timothy Gage, Robert Presley, Arnold Schwarzenegger *Defendants' Response to Order to Show Cause*. (Tama, Samantha) (Filed on 6/4/2007) (Entered: 06/04/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/11/2007	705	NOTICE by Robert Sillen *Receiver's Supplemental Report re Overcrowding* (Dodd, Martin) (Filed on 6/11/2007) (Entered: 06/11/2007)
06/11/2007	706	Declaration of John Haga *Declaration of John Hagar in Support of Receiver's Supplemental Report re Overcrowding* filed by Robert Sillen. (Attachments: #

Date Filed	Plata # / [Coleman #]	Docket Text
		1 Exhibit 1# 2 Exhibit 2# 3 Exhibit 3# 4 Exhibit 4# 5 Exhibit 5# 6 Exhibit 6# 7 Exhibit 7# 8 Exhibit 8# 9 Exhibit 9# 10 Exhibit 10# 11 Exhibit 11# 12 Exhibit 12# 13 Certificate of Service) (Dodd, Martin) (Filed on 6/11/2007) (Entered: 06/11/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/15/2007	709	Reply Memorandum *Receiver's Reply Memorandum in Support of Motion for Waiver of State Law re Clinical Competency Determinations* filed by Robert Sillen. (Dodd, Martin) (Filed on 6/15/2007) (Entered: 06/15/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/15/2007	715	REPLY to Response to Motion *by Receiver for State Law Waiver re Physician Clinical Comptency Determinations* filed by Marciano Plata. (Fama, Steven) (Filed on 6/15/2007) (Entered: 06/15/2007)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
06/18/2007	717	RESPONSE to *Defendants' Response to Receiver's Supplemental Report Re Overcrowding* by Arnold Schwarzenegger. (Tama, Samantha) (Filed on 6/18/2007) (Entered: 06/18/2007)
06/18/2007	718	Declaration of Scott Kernan in Support of 717 Response (Non Motion) *Defendants' Response to Receiver's Supplemental Report re Overcrowding* filed by Arnold Schwarzenegger. (Related document(s) 717) (Tama, Samantha) (Filed on 6/18/2007) (Entered: 06/18/2007)
06/18/2007	719	RESPONSE in Support *Motion to Convene 3-Judge Panel* filed by California Correctional Peace Officers' Association. (Stoughton, Jennifer) (Filed on 6/18/2007) (Entered: 06/18/2007)
06/18/2007	720	Declaration of Jennifer S. Stoughton in Support of 719 Response in Support *Motion to Convene 3-Judge Panel*

Date Filed	Plata # / [Coleman #]	Docket Text
		filed by California Correctional Peace Officers' Association. (Attachments: # 1 Signature Page (Declarations/Stipulations) # 2 Exhibit a# 3 Exhibit B# 4 Exhibit C# 5 Exhibit D# 6 Exhibit E# 7 Exhibit F# 8 Exhibit G)(Related document(s) 719) (Stoughton, Jennifer) (Filed on 6/18/2007) (Entered: 06/18/2007)

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06/20/2007	723	STATUS REPORT *Receiver's Fifth Quarterly Report* by Robert Sillen. (Hector, Kristina) (Filed on 6/20/2007) (Entered: 06/20/2007)

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06/21/2007	725	RESPONSE to re 709 Reply Memorandum *Request for Hearing Re Receiver's Motion for Waiver of State Law Re Physician Clinical Competency Determination* by California State Personnel Board. (Tigno, Fiel) (Filed on 6/21/2007) (Entered: 06/21/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
06/26/2007	726	RESPONSE to *Receiver's and Plaintiffs' Reply Briefs re Clinical Competency Determinations* by Union of American Physicians & Dentists. (More, Paul) (Filed on 6/26/2007) (Entered: 06/26/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/27/2007	730	NOTICE by Robert Sillen *Receiver's Supplemental Application No. 1 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts and Approving Nunc Pro Tunc ACNL Supervisory Nurse Training Contract* (Dodd, Martin) (Filed on 6/27/2007) (Entered: 06/27/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/27/2007	735	MINUTES (Text Only) for proceedings held before Judge Lawrence K. Karlton and Judge Thelton E. Henderson: JOINT MOTION

Date Filed	Plata # / [Coleman #]	Docket Text
		HEARING (C01-1351 TEH) held on 6/27/2007 re 2036 MOTION To Convene a Three Judge Panel to Limit the Prison Population filed by Ralph Coleman. After oral argument, the matters stand SUBMITTED. Courts to issue formal order. Plaintiffs Counsel Michael Bien, Jane Kahn, Lori Rifkin, Donald Specter present. Defendants Counsel Lisa Tillman, Misha Igra, Rochelle East and Paul Mello present. Ronald Yank for CCPOA. Michael Keating and Matthew Lopes present. Robert Sillen and John Hagar present. Court Reporter: C. Bodene.(Rivas, A) **THIS HEARING IS HELD IN THE EASTERN DISTRICT OF CALIFORNIA; THERE IS NO DOCUMENT ATTACHED** (rbe, COURT STAFF) (Filed on 6/27/2007) (Entered: 06/27/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/28/2007	737	ORDER APPROVING COORDINATION AGREE-

Date Filed	Plata # / [Coleman #]	Docket Text
		MENTS ATTACHED TO MAY 29, 2007 ORDER. Signed by Judge Thelton E. Henderson on June 28, 2007. (tehlc1, COURT STAFF) (Filed on 6/28/2007) (Entered: 06/28/2007)
06/28/2007	738	MOTION for Joinder *DEFENDANTS' RESPONSE AND JOINDER TO THE RECEIVERS MOTION FOR AN ORDER MODIFYING THE STIPULATED INJUNCTION AND OTHER ORDERS* filed by Arnold Schwarzenegger. Motion Hearing set for 8/9/2007 10:30 AM. (Antonen, Charles) (Filed on 6/28/2007) (Entered: 06/28/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/29/2007	740	RESPONSE to *Defendants' Response To The Receiver's May 2007 Plan Of Action* by Arnold Schwarzenegger. (Antonen, Charles) (Filed on 6/29/2007) (Entered: 06/29/2007)
06/29/2007	741	RESPONSE to re 658 Notice (Other) *Receiver's Plan of*

Date Filed	Plata # / [Coleman #]	Docket Text
		Action by Marciano Plata. (Norman, Sara) (Filed on 6/29/2007) (Entered: 06/29/2007)
06/29/2007	742	Declaration of Steven Fama in Support of 741 Response (Non Motion) *Plaintiffs' Response to Receiver's Plan of Action* filed byMarciano Plata. (Attachments: # 1) (Related document(s) 741) (Norman, Sara) (Filed on 6/29/2007) (Entered: 06/29/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/29/2007	744	MOTION For An Order Directing The Receiver To Comply With The April 4, 2003 Order Re Production And Access To Documents And/Or Modifying The Order Appointing The Receiver filed by Marciano Plata. Motion Hearing set for 8/9/2007 10:30 AM in Courtroom 12, 19th Floor, San Francisco. (Fama, Steven) (Filed on 6/29/2007) (Entered: 06/29/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
06/29/2007	745	Declaration of Steven Fama in Support of 744 MOTION For An Order Directing The Receiver To Comply With The April 4, 2003 Order Re Production And Access To Documents And/Or Modifying The Order Appointing The Receiver filed byMarciano Plata. (Attachments: # 1 Exhibit Exhibits A-I to Declaration)(Related document(s) 744) (Fama, Steven) (Filed on 6/29/2007) (Entered: 06/29/2007)
		* * * *
06/29/2007	747	Memorandum in Opposition *To Receiver's Motion to Modify Stipulated Injunction and Other Orders* filed byMarciano Plata. (Specter, Donald) (Filed on 6/29/2007) (Entered: 06/29/2007)
		* * * *
07/02/2007	752	Request for Judicial Notice *DEFENDANTS' FURTHER STATEMENT ADDRESSING PLAINTIFFS' MOTION TO CONVENE A*

Date Filed	Plata # / [Coleman #]	Docket Text
		THREE-JUDGE PANEL TO ADDRESS POPULATION ISSUES filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A# 2 Exhibit b# 3 Exhibit c# 4 Exhibit d# 5 Exhibit e)(Antonen, Charles) (Filed on 7/2/2007) (Entered: 07/02/2007)

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07/03/2007	754	ORDER requesting additional briefing on 561 MOTION to Convene a Three Judge Panel. Signed by Judges Lawrence K. Karlton and Thelton E. Henderson on 07/03/07. (tehlc3, COURT STAFF) (Filed on 7/3/2007) (Entered: 07/03/2007)

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07/03/2007	758	ORDER by Judge Thelton E. Henderson Re 642 Receiver's Motion for Waiver of State Law Re Reciever Career Executive Assignments 642 (tehlc1, COURT STAFF)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 7/3/2007) (Entered: 07/03/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/06/2007	763	RESPONSE to Receiver's Reply in Support of Motion for Waiver of State Law Re Physician Competency Determinations filed by California State Personnel Board. (Attachments: # 1 Exhibit SPB Liou Decision)(Neri, Miguel) (Filed on 7/6/2007) Modified on 7/10/2007 (far, COURT STAFF). (Entered: 07/06/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/11/2007	765	RESPONSE to *Defendants' Brief Re: Expert Panel's Report On Reentry And Recidivism And Its Relation To Pending Motion To Convene A Three-Judge Panel* by Arnold Schwarzenegger. (Antonen, Charles) (Filed on 7/11/2007) (Entered: 07/11/2007)
07/11/2007	766	Declaration *Of Joan Petersilia In Support of Defendants' Additional Briefing On*

Date Filed	Plata # / [Coleman #]	Docket Text
		Plaintiff's Motion To Convene Three-Judge Court filed by Arnold Schwarzenegger. (Antonen, Charles) (Filed on 7/11/2007) (Entered: 07/11/2007)
07/11/2007	767	Declaration *Of Kathryn Jett In Support of Defendants' Additional Briefing On Plaintiffs' Motion To Convene Three-Judge Court* filed by Arnold Schwarzenegger. (Antonen, Charles) (Filed on 7/11/2007) (Entered: 07/11/2007)
07/12/2007	768	Statement of Non-Opposition *Defendants' Statement of Non-Opposition To Receiver's Supplemental Application No. 1 For An Order Waiving State Contracting Statutes, Regulations And Procedures, Approving Receiver's Substitute Procedures For Bidding And Award Of Contracts, And Approving Nunc Pro Tunc ACNL Supervisory Nurse Training Contract* filed by Arnold Schwarzenegger. (Antonen, Charles) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		7/12/2007) (Entered: 07/12/2007)
07/12/2007	769	RESPONSE to re 736 Order *re Receiver's Supplemental Application No. 1* by Marciano Plata. (Fama, Steven) (Filed on 7/12/2007) (Entered: 07/12/2007)
		* * * *
07/17/2007	771	Reply Memorandum *Receiver's Reply Memorandum in Support of His Supplemental Application No. 1 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts and Approving Nunc Pro Tunc ACNL Supervisory Nurse Training Contract* filed byRobert Sillen. (Dodd, Martin) (Filed on 7/17/2007) (Entered: 07/17/2007)
		* * * *
07/17/2007	773	Reply Memorandum *Regarding Relation of Expert Panel Report to Plaintiffs' Motion*

Date Filed	Plata # / [Coleman #]	Docket Text
		to Convene a Three-Judge Court filed by Marciano Plata. (Specter, Donald) (Filed on 7/17/2007) (Entered: 07/17/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/23/2007	780	ORDER by Judge Thelton E. Henderson granting 561 Plaintiffs' motion to convene three-judge court. (tehlc3, COURT STAFF) (Filed on 7/23/2007) (Entered: 07/23/2007)
07/23/2007	781	Memorandum in Opposition *Receiver's Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for an Order Directing Receiver to Comply with the April 4, 2003 Order re Production and Access to Documents and/or Modifying the Order Appointing Receiver* filed byRobert Sillen. (Dodd, Martin) (Filed on 7/23/2007) (Entered: 07/23/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/26/2007	784 /	ORDER designating United States District Court com-

Date Filed	Plata # / [Coleman #]	Docket Text
	[2328]	posed of three judges pursuant to Section 2284, Title 28 United States Code. Signed by Chief Judge Mary M. Schroeder, United States Court of Appeals for the Ninth Circuit, on 07/26/07.(tehlc3, COURT STAFF) (Filed on 7/26/2007) (Entered: 07/26/2007)
07/27/2007	785 / [2330]	MOTION to Stay *Defendants' Motion For Stay Pending Appeal* filed by Arnold Schwarzenegger. (Tama, ma, Samantha) (Filed on 7/27/2007) (Entered: 07/27/2007)
07/27/2007	799 / [2331]	NOTICE OF APPEAL as to re 780 Order Granting Plaintiffs' Motion to Convene Three-Judge Court - [Filing Fee: $455.00, Receipt Number 34611008836] Filed by Defendants. (tn, COURT STAFF) (Filed on 7/27/2007) (Entered: 07/31/2007)
07/30/2007	786	Reply Memorandum *Receiver's Reply to Plaintiffs' Response to Plan of Action* filed byRobert Sillen. (Dupree,

Date Filed	Plata # / [Coleman #]	Docket Text
		Jamie) (Filed on 7/30/2007) (Entered: 07/30/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/30/2007	789	Reply to Opposition re 744 MOTION For An Order Directing The Receiver To Comply With The April 4, 2003 Order Re Production And Access To Documents And/Or Modifying The Order Appointing The Receiver filed byMarciano Plata. (Norman, Sara) (Filed on 7/30/2007) (Entered: 07/30/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/30/2007	791	ORDER DENYING WITHOUT PREJUDICE RECEIVER'S REQUEST FOR PERMISSION TO FILE MOTIONS TO IMPLEMENT RECOMMENDATIONS IN OVERCROWDING REPORT. Signed by Judge Thelton E. Henderson on July 30, 2007. (tehlc1, COURT STAFF) (Filed on 7/30/2007) (Entered: 07/30/2007)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
07/30/2007	793	Reply Memorandum *Receiver's Reply Memorandum in Support of Motion for Order Modifyinig Stipulated Injunction and Other Orders Entered Herein* filed byRobert Sillen. (Dupree, Jamie) (Filed on 7/30/2007) (Entered: 07/30/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/31/2007	797 / [2340]	ORDER by three-judge court requiring status statements within fifteen calendar days. The parties shall file all documents relating to proceedings before the three-judge court in both this case and *Coleman v. Schwarzenegger*, Case No. CIV S-90-0520 LKK JFM P (E.D. Cal.), with the caption as indicated in this order. Signed by Judges Reinhardt, Karlton, and Henderson on 07/31/07. (tehlc3, COURT STAFF) (Filed on 7/31/2007) (Entered: 07/31/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/07/2007	801 / [2352]	AMENDED NOTICE OF APPEAL as to the Court's re 780 Order Granting Motion to Convene a Three-Judge Court Filed by Defendants. (tn, COURT STAFF) (Filed on 8/7/2007) (Entered: 08/09/2007)
08/13/2007	802 / [2362]	ORDER GRANTING 730 RECEIVER'S SUPPLEMENTAL APPLICATION NO. 1 FOR ORDER WAIVING STATE CONTRACTING STATUTES ETC. Signed by Judge Thelton E. Henderson on August 13, 2007. (tehlc1, COURT STAFF) (Filed on 8/13/2007) (Entered: 08/13/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/17/2007	817 / [2376]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson granting 803 811 816 Motions to Intervene and referring discovery disputes to Magistrate Judge John F. Moulds, United States District Court for the Eastern District of Califor-

Date Filed	Plata # / [Coleman #]	Docket Text
		nia. (tehlc3, COURT STAFF) (Filed on 8/17/2007) (Entered: 08/17/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/23/2007	821	REPORTER'S TRANSCRIPT of Proceedings Held on 6/27/2007 before Judge Thelton E. Henderson - [Court Reporter: Catherine E.F. Bodene]. (tn, COURT STAFF) (Filed on 8/23/2007) (Entered: 08/24/2007)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
09/06/2007	826	ORDER (1) RE RECEIVER'S MAY 2007 PLAN OF ACTION, (2) GRANTING IN PART AND DENYING IN PART RECEIVER'S MOTION FOR ORDER MODIFYING STIPULATED INJUNCTION AND ORDERS ENTERED HEREIN, (3) DENYING PLAINTIFFS' MOTION FOR ORDER DIRECTING RECEIVER TO COMPLY WITH APRIL 4, 2004 ORDER, (4) GRANTING PLAINTIFFS' MOTION TO FILE SUR REPLY, AND (5) APPOINTING

Date Filed	Plata # / [Coleman #]	Docket Text
		FACILITATOR. Signed by Judge Thelton E. Henderson on September 6, 2007. (tehlc1, COURT STAFF) (Filed on 9/6/2007) (Entered: 09/06/ 2007)
09/11/2007	827	ORDER RE 642 by Judge Thelton E. Henderson ADOPTING AUGUST 20, 2007 STIPULATION BETWEEN RECEIVER AND STATE PERSONNEL BOARD (tehlc1, COURT STAFF)(filed on 9/11/2007) (Entered: 09/11/2007)
	* * * *	
09/19/2007	857 / [2427]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson granting 828 830 835 840 841 848 849 Motions to Intervene filed on September 14, 2007. (tehlc3, COURT STAFF) (Filed on 9/19/2007) (Entered: 09/19/ 2007)
	* * * *	
09/25/2007	863 /	Minute Entry: Case Management Conference re:

Date Filed	Plata # / [Coleman #]	Docket Text
	[2423]	Three-Judge Court held on 9/24/2007 before Judge Thelton E. Henderson, Judge Lawrence Karlton and Judge Stephen Reinhardt. (Court Reporter: Belle Ball) (rbe, COURT STAFF) (Date Filed: 9/25/2007) (Entered: 09/25/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/25/2007	865 / [2434]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson re: discovery. Discovery in proceedings before three-judge court is open. Responses to written discovery already served shall be due in thirty days. (tehlc3, COURT STAFF) (Filed on 9/25/2007) (Entered: 09/25/2007)
09/25/2007	866	*Receiver's Sixth Quarterly Report* by Robert Sillen. (Hector, Kristina) (Filed on 9/25/2007) (Entered: 09/25/2007)
09/25/2007	867	*Exhibits to Receiver's Sixth Quarterly Report* by Robert Sillen. (Attachments: #(1)

Date Filed	Plata # / [Coleman #]	Docket Text
		Exhibit Exhibits #2, 3, #(2) Exhibit Exhibits #4-8, #(3) Exhibit Exhibit 9, #(4) Exhibit Exhibits 10-12, #(5) Exhibit Exhibits 13-17). (Hector, Kristina) (Filed on 9/25/2007) (Entered: 09/25/2007)

* * * *

10/10/2007	880 / [2456]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson bifurcating proceedings before three-judge court and setting deadlines for Phase I. (tehlc3, COURT STAFF) (Filed on 10/10/2007) (Entered: 10/10/2007)

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10/19/2007	884	REPORTER'S TRANSCRIPT of Proceedings Held on 9/24/2007 before Judge Thelton E. Henderson - [Court Reporter: Belle Ball]. (tn, COURT STAFF) (Filed on 10/19/2007) (Entered: 10/22/ 2007)
10/19/2007	885 / [2467]	United States Court of Appeals for the Ninth Circuit JUDGMENT as to re 799

Date Filed	Plata # / [Coleman #]	Docket Text
		Notice of Appeal: On consideration whereof, it is now here ordered & adjudged by this Court, that the Appeal in this cause be, and hereby is DISMISSED for Lack of Jurisdiction. (tn, COURT STAFF) (Filed on 10/19/2007) (Entered: 10/22/2007)
	* * * *	
10/22/2007	887 / [2470]	*"Joint Statement Regarding Discovery Disputes"* filed by Marciano Plata. (Whelan, Amy) (Filed on 10/22/2007) (Entered: 10/22/2007)
	* * * *	
10/24/2007	901	NOTICE OF APPEAL as to the Court's re 864 Order Denying Motion to Intervene - [No Filing Fee Received] Filed by Prisoner Miguel Diaz, #T-83077. (tn, COURT STAFF) (Filed on 10/24/2007) Additional attachment(s) added on 10/26/2007 (tn, COURT STAFF). (Entered: 10/26/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2007	906 / [2495]	ORDER re: 887 discovery disputes. Signed by Magistrate Judge John F. Moulds (E.D. Cal.) on 10/30/07. (tehlc3, COURT STAFF) (Filed on 10/30/2007) (Entered: 10/30/2007)
11/01/2007	907 / [2499]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson appointing settlement referee and consultant. Elwood Lui, Esq., shall serve as a settlement referee, and the Honorable Peter Siggins shall serve as a consultant and advisor to the settlement referee. (tehlc3, COURT STAFF) (Filed on 11/1/2007) (Entered: 11/01/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/09/2007	925 / [2521]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Judge Thelton E. Henderson Granting In Part and Denying In Part 891 Motion for Reconsideration and Denying As Moot 911 Motion to Stay (tehlc4,

Date Filed	Plata # / [Coleman #]	Docket Text
		COURT STAFF) (Filed on 11/9/2007) Additional attachment(s) added on 11/9/2007 (tehlc4, COURT STAFF). (Entered: 11/09/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/15/2007	928	NOTICE by Robert Sillen *Notice of Filing of Receiver's November 15, 2007 Plan of Action and Appendices Thereto* (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	929	*Receiver's Plan of Action - Part 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	930	*Receiver's Plan of Action - Part 2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	931	*5000 Medical Bed Project Initiative Appendix 1* by Robert Sillen. (Dodd, Martin)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	932	*5000 Medical Bed Project Initiative Appendices 2-3, part 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	933	*5000 Medical Bed Project Initiative Appendices 2-3, part 2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	934	*Clinical Initiative Appendices Appendix 1-3 and 5* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	935	*Clinical Initiative Appendices Appendix 4, part 1 of 2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	936	*Clinical Initiative Appendices Appendix 4, part 2 of 2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
11/15/2007	937	*Clinical Operations Initiative Appendix 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/ 2007)
11/15/2007	938	*Clinical Quality Measurement and Evaluation Initiative Appendix 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	939	*Contract and Invoice Processing Initiative Appendix 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/ 2007)
11/15/2007	940	*Custody Access Initiative Appendices 1-5* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/ 2007)
11/15/2007	941	*Facility Improvement Construction Initiative Appendix 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/ 2007) (Entered: 11/15/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
11/15/2007	942	*Facility Improvement Construction Initiative Appendix 2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	943	*Fiscal Services Initiative Appendices 1-2 and 4-5* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	944	*Fiscal Services Initiative Appendix 3* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	945	*Health Care Appeals Correspondence Control and Habeas Corpus Petitions Initiative Appendices 1-5* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	946	*Information Technology Initiative Appendices 1-7* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
11/15/2007	947	*Maxor Pharmacy Services Initiative Appendices 1-2* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	948	*San Quentin Pilot Project Initiative Appendix 1* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/15/2007	949	*Specialty Services Coordination Pilot Initiative Appendices 1-4* by Robert Sillen. (Dodd, Martin) (Filed on 11/15/2007) (Entered: 11/15/2007)
11/16/2007	950	NOTICE by Robert Sillen *Amended Notice of Filing of Receiver's November 15, 2007 Plan of Action and Appendices Thereto* (Dodd, Martin) (Filed on 11/16/2007) (Entered: 11/16/2007)
11/19/2007	951 / [2539]	*Defendants' STATEMENT Regarding Discovery Disputes* Filed by James E. Tilton, Michael C. Genest & Arnold Schwarzenegger. (Antonen, Charles) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		11/19/2007) (Entered: 11/19/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/19/2007	954 / [2537]	*Plaintiffs' STATEMENT Regarding Discovery Disputes* filed by Ralph Coleman. (Rifkin, Lori) (Filed on 11/19/2007) (Entered: 11/19/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/19/2007	958 / [2543]	*Receiver's STATEMENT Regarding Discovery Dispute* Filed by Robert Sillen, Receiver. (Dodd, Martin) (Filed on 11/19/2007) (Entered: 11/19/2007)
11/20/2007	959	NOTICE by Robert Sillen *Receiver's Supplemental Application No. 2 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* (Dodd, Martin) (Filed on 11/20/2007) (Entered: 11/20/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
		* * * *
11/20/2007	962 / [2547]	*Defendants' MOTION For Reconsideration Or, In The Alternative, Motion For Stay Of Order To Produce Disk, With Declaration Of Lisa Tillman* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (East, Rochelle) (Filed on 11/20/2007) (Entered: 11/20/2007)
		* * * *
11/20/2007	964 / [2549]	ORDER by Magistrate Judge John F. Moulds (E.D. Cal.) re: 951 954 discovery disputes. (tehlc3, COURT STAFF) (Filed on 11/20/2007) (Entered: 11/20/2007)
11/20/2007	965 / [2550]	STIPULATION *Re Institution-Specific Discovery* by Arnold Schwarzenegger. (Antonen, Charles) (Filed on 11/20/2007) (Entered: 11/20/2007)
11/21/2007	966 / [2554]	MOTION for Reconsideration re 964 Order on Motion for Discovery, filed by James

Date Filed	Plata # / [Coleman #]	Docket Text
		E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (East, Rochelle) (Filed on 11/21/2007) (Entered: 11/21/2007)
	* * * *	
11/26/2007	968 / [2555]	*Joint Statement Regarding Dispute of Discovery* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Tama, Samantha) (Filed on 11/26/2007) (Entered: 11/26/2007)
	* * * *	
11/26/2007	978 / [2551]	Memorandum in Opposition re 966 MOTION for Reconsideration re 964 Order on Motion for Discovery, filed byMarciano Plata. (Rifkin, Lori) (Filed on 11/26/2007) (Entered: 11/26/2007)
	* * * *	
11/27/2007	981	*Receiver's SUPPLEMENTAL APPLICATION No. 3 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute*

Date Filed	Plata # / [Coleman #]	Docket Text
		Procedure for Bidding and Award of Contracts Filed by Receiver Robert Sillen. (Dodd, Martin) (Filed on 11/27/2007) (Entered: 11/27/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/27/2007	984 / [2572]	ORDER by Magistrate Judge John F. Moulds (E.D. Cal.) denying 962 Motion for Reconsideration. (tehlc3, COURT STAFF) (Filed on 11/27/2007) (Entered: 11/27/2007)
11/27/2007	985 / [2573]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 966 Motion for Reconsideration. (tehlc3, COURT STAFF) (Filed on 11/27/2007) (Entered: 11/27/2007)
11/28/2007	986 / [2574]	ORDER by Magistrate Judge John F. Moulds (E.D. Cal.) granting in part and denying in part 968 Motion for Discovery.(tehlc3, COURT STAFF) (Filed on 11/28/ 2007) (Signed on 11/27/2007) (Entered: 11/28/2007)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
11/29/2007	988 / [2577]	PROTECTIVE ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson re: deposition of the California Prison Health Care Receivership Corporation. (tehlc3, COURT STAFF) (Filed on 11/29/2007) (Entered: 11/29/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/03/2007	992 / [2581]	MOTION to Compel *Production of Documents* filed by Marciano Plata. Motion Hearing set for 12/6/2007 02:00 PM. (Rifkin, Lori) (Filed on 12/3/2007) (Entered: 12/03/2007)
12/03/2007	993 / [2582]	Brief re 992 MOTION to Compel *Production of Documents* filed byMarciano Plata. (Related document(s) 992) (Rifkin, Lori) (Filed on 12/3/2007) (Entered: 12/03/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/05/2007	996 / [2591]	Memorandum in Opposition re 992 MOTION to Compel *Production of Documents* filed byArnold Schwarzenegger. (Antonen, Charles) (Filed on 12/5/2007) (Entered: 12/05/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/07/2007	1001 / [2600]	ORDER by Magistrate Judge John F. Moulds (E.D. Cal.) granting 992 Plaintiffs' Motion to Compel. (tehlc3, COURT STAFF) (Filed on 12/7/2007) (Signed on 12/6/2007) (Entered: 12/07/2007)
12/07/2007	1002 / [2601]	First MOTION for Reconsideration *by the Three-Judge Panel of Magistrate Judge's Order or, Alternatively, Request for Stay of Order (E.D.L.R. 72-303)* filed by Arnold Schwarzenegger. (Attachments: # 1 Supplement Proof of Service)(Igra, Michelle) (Filed on 12/7/2007) (Entered: 12/07/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/07/2007	1009	NOTICE OF APPEAL as to the Court's Order re 925 Order on Motion for Reconsideration and/or Clarification and Order Consolidating Republican Assembly & Senate Interventions & re 880 Order Bifurcating Proceedings & Setting Deadlines for Phase I Filed by Intervenors Anthony Adams, Greg Aghazarian, Joel Anderson, John J. Benoit, Tom Berryhill, Sam Blakeslee, Paul Cook,, Chuck DeVore, Michael D. Duvall, Bill Emmerson, Jean Fuller, Ted Gaines, Martin Garrick, Shirley Horton, Guy S. Houston, Bob Huff, Kevin Jeffries, Rick Keene, Doug La Malfa, Bill Maze, Alan Nakanishi, Roger Niello,, George A. Plescia, Sharon Runner, Jim Silva, Cameron Smyth, Todd Spitzer, Audra Strickland, Van Tran, Michael N. Villines, Mimi Walters, San Diego County Sheriff William B. Kolender, Orange County Sheriff Coroner Michael S. Carona, Placer County Sheriff Ed-

Date Filed	Plata # / [Coleman #]	Docket Text
		ward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe,

Date Filed	Plata # / [Coleman #]	Docket Text
		Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, Samuel Aanestad, Dick Ackerman, James F. Battin, Jr, Dave Cogdill, Dave Cox, Jeff Denham, Bob Dutton, Dennis Hollingsworth, Abel Maldonado, George Runner, Bob Margett, Mark Wyland, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom, Stanislaus County Sheriff Adam Christianson, Sutter County Sheriff Jim Denney, Lake County Sheriff Rod Mitchell, Tuolumne County Sheriff Jim Mele, Monterey County Sheriff Mike Kanalakis, Mono County Sheriff Richard Scholl, Humboldt County Sheriff Gary Philp, Merced County Sheriff Mark Pazin, Del Norte County Sheriff Dean Wilson, San Joaquin County Sheriff Steve Moore, Amador County Sheriff Martin Ryan, Inyo County Sheriff William Lutze, Solano County Chief Probation Of-

Date Filed	Plata # / [Coleman #]	Docket Text
		ficer Isabelle Voit, Butte County Chief Probation Officer John Wardell, San Luis Obispo County Chief Probation Officer Kim Barrett, Contra Costa County Chief Probation Officer Lionel Chatman, Shasta County Chief Probation Officer Brian Richart, Yolo County Chief Probation Officer Don Meyer, Fresno County Chief Probation Officer Linda Penner, Mariposa County Chief Probation Officer Gail Neal, City of Whittier Police Chief Dave Singer, City of Roseville Police Chief Joel Neves, City of Pasadena Police Chief Barney Melekian, City of Alhambra Police Chief Jim Hudson, City of Fremont Police Chief Craig Steckler, City of Grover Beach Police Chief Jim Copsey, City of Santa Clara Police Chief Steve Lodge, City of Vacaville Police Chief Rich Word, City of Woodland Police Chief Carey Sullivan, City of Sonora Police Chief Mace McIntosh, City of Paso Robles Police Chief Lisa So-

Date Filed	Plata # / [Coleman #]	Docket Text
		lomon, City of San Bernardino Police Chief Michael Billdt, City of Atwater Police Chief Richard Hawthorne, National City Police Chief Adolfo Gonzales, City of Delano Police Chief Mark DeRosia, City of Modesto Police Chief Roy Wasden, City of Fresno Police Chief Jerry Dyer, City of Delano Chief of Corrections George Galaza, San Luis Obispo County Sheriff Pat Hedges, Glenn County Sheriff Larry Jones, Fresno County Sheriff Margaret Mims, El Dorado County Sheriff Jeff Neves, Santa Barbara County Chief Probation Officer Patricia Stewart, Inyo County Chief Probation Officer Jim Moffett, San Mateo County Sheriff Greg Munks & Ventura County Chief Probation Officer Karen Staples - [Filing Fee: $455.00, Receipt Number 34611013316]. (tn, COURT STAFF) (Filed on 12/7/2007) (Entered: 12/10/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
12/10/2007	1007 / [2606]	Memorandum in Opposition to re 1002 First MOTION for Reconsideration *by the Three-Judge Panel of Magistrate Judge's Order or, Alternatively, Request for Stay of Order (E.D.L.R. 72-303) and Request for Sanctions* Filed by Marciano Plata. (Rifkin, Lori) (Filed on 12/10/ 2007) (Entered: 12/10/2007)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
12/11/2007	1010 / [2609]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson staying 1001 Order on Motion to Compel and ORDER setting status conference for 12/13/07 at 10:00 AM. (tehlc3, COURT STAFF) (Filed on 12/11/ 2007) (Entered: 12/11/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/14/2007	1017 / [2620]	ORDER staying proceedings. All pretrial and trial dates in the three-judge court proceedings are vacated. 1002 Defendants' motion for re-

Date Filed	Plata # / [Coleman #]	Docket Text
		consideration is denied. Defendants' request for additional time to review and revise privilege logs is granted in part. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 12/14/07. (tehlc3, COURT STAFF) (Filed on 12/14/2007) Modified on 12/14/2007 (tehlc3, COURT STAFF). (Entered: 12/14/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/14/2007	1027	REPORTER'S TRANSCRIPT of Proceedings Held on 12/13/2007 before Judge Thelton E. Henderson - [Court Reporter: Katherine A. Powell]. (tn, COURT STAFF) (Filed on 12/14/2007) (Entered: 12/20/2007)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/20/2007	1026	ORDER granting 981 Receiver's Supplemental Application No. 3 for waiver of state law. Signed by Judge Thelton E. Henderson on 12/20/07. (tehlc3, COURT STAFF) (Filed on 12/20/2007) (Entered: 12/20/2007)

Date Filed	Plata # / [Coleman #]	Docket Text
12/21/2007	1029	NOTICE by Robert Sillen *Notice of Filing of Receiver's 90-Day Report Re Receiver's Career Executive Assignments and Receiver's Report re Receiver's Career Executive Assignments* (Dodd, Martin) (Filed on 12/21/2007) (Entered: 12/21/2007)
12/21/2007	1030 / [2625]	NOTICE by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger *Defendants' Request for Clarification of the Three-Judge Panel's December 14, 2007 Order* (Antonen, Charles) (Filed on 12/21/2007) (Entered: 12/21/2007)
12/21/2007	1031	Reply Memorandum *in Support of His Supplemental Application No. 2 For Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* filed byRobert Sillen. (Dodd, Martin) (Filed on 12/21/2007) (Entered: 12/21/2007)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
01/04/2008	1037	NOTICE by Robert Sillen *Notice of Filing of Stipulation Between Receiver Robert Sillen and California Department of Personnel Administration re LVN Salary Administration* (Dodd, Martin) (Filed on 1/4/2008) (Entered: 01/04/2008)
01/07/2008	1038	NOTICE by Robert Sillen *Receiver's Report and Supplemental Memorandum in Support of Motion for Waiver of State Law re Physician Clinical Competency Determinations* (Dodd, Martin) (Filed on 1/7/2008) (Entered: 01/07/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/07/2008	1045 / [2630]	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to the Court Orders re 1017 & 1001 Filed by Defendants James E. Tilton, Michael C. Genest, Arnold Schwarzenegger & Stephen Mayberg - [Filing Fee:

Date Filed	Plata # / [Coleman #]	Docket Text
		$455.00, Receipt Number 34611014241]. (tn, COURT STAFF) (Filed on 1/7/2008) (Entered: 01/08/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/09/2008	1046	STIPULATION AND ORDER re 1037 LVN salary administration. Signed by Judge Thelton E. Henderson on 01/09/08. (rbe, COURT STAFF) (Filed on 1/9/2008) (Entered: 01/09/2008)
01/10/2008	1047 / [2632]	Brief *"Request for Clarification of Discovery Stay Order with Respect to Noticed Spoliation Deposition"* filed by-Marciano Plata. (Whelan, Amy) (Filed on 1/10/2008) (Entered: 01/10/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/11/2008	1051	ORDER requiring supplemental briefing re: Receiver's motion for waiver of state law re: physician clinical competency determinations. Signed by Judge Thelton E. Henderson on 01/11/08. (tehlc3, COURT STAFF) (Filed on 1/11/2008) (Entered: 01/11/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
		* * * *
01/15/2008	1054 / [2641]	Memorandum in Opposition *Defendants Opposition to Plaintiffs Request for Clarification of Discovery Stay* filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Antonen, Charles) (Filed on 1/15/2008) (Entered: 01/15/2008)
		* * * *
01/17/2008	1059 / [3647]	ORDER re 1047 Plaintiffs' request for clarification. Signed by Judge John F. Moulds (E.D. Cal.) on 01/17/08. (tehlc3, COURT STAFF) (Filed on 1/17/2008) (Entered: 01/17/2008)
		* * * *
01/22/2008	1060	*SUPPLEMENTAL Opposition to Receiver's Motion for Waiver of State Law Re Physician Clinical Competency Determinations* Filed by California State Personnel Board. (Neri, Miguel) (Filed on 1/22/2008) (Entered: 01/22/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
01/22/2008	1062	*SUPPLEMENTAL Opposition to Receiver's Motion for Waiver of State Law re Physician Clinical Competency Determinations* Filed by Marciano Plata. (Fama, Steven) (Filed on 1/22/2008) (Entered: 01/22/2008)
01/23/2008	1063	ORDER appointing new Receiver. Signed by Judge Thelton E. Henderson on 01/23/08. (tehlc3, COURT STAFF) (Filed on 1/23/2008) (Entered: 01/23/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/25/2008	1066	ORDER granting in part and denying in part 959 Receiver's Supplemental Application No. 2 for waiver of state law. Signed by Judge Thelton E. Henderson on 01/25/08. (tehlc3, COURT STAFF) (Filed on 1/25/2008) (Entered: 01/25/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/28/2008	1068 / [2650]	MOTION for Reconsideration *Notice of Motion and Renewed Motion for Reconsideration; Memorandum of Points and Authorities* filed by Anthony Adams, Greg Aghazarian, Joel Anderson, John J. Benoit, Tom Berryhill, Sam Blakeslee, Paul Cook,, Chuck DeVore, Michael D. Duvall, Bill Emmerson, Jean Fuller, Ted Gaines, Martin Garrick, Shirley Horton, Guy S. Houston, Bob Huff, Kevin Jeffries, Rick Keene, Doug La Malfa, Bill Maze, Roger Niello,, George A. Plescia, Sharon Runner, Jim Silva, Cameron Smyth, Todd Spitzer, Audra Strickland, Michael N. Villines, Mimi Walters, Samuel Aanestad, Dick Ackerman, Roy Ashburn, James F. Battin, Jr, Dave Cogdill, Dave Cox, Jeff Denham, Bob Dutton, Dennis Hollingsworth, Abel Maldonado, George Runner, Bob Margett, Mark Wyland. (Attachments: # 1 Proposed Order Proposed Order) (Stegeman, Chad) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		1/28/2008) (Entered: 01/28/2008)
		* * * *
01/29/2008	1078 / [2662]	ORDER by Judge John F. Moulds (E.D. Cal.) granting 1071 Defendants' motion for extension of time to complete discovery, denying Defendants' motion for protective order, and setting various discovery deadlines. (tehlc3, COURT STAFF) (Filed on 1/29/2008) (Entered: 01/29/ 2008)
		* * * *
02/04/2008	1080 / [2664]	Statement of Non-Opposition re 1068 MOTION for Reconsideration *Notice of Motion and Renewed Motion for Reconsideration; Memorandum of Points and Authorities Defendants' Non-Opposition to Intervenors' Renewed Motion for Reconsideration* filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Related document(s) 1068) (East, Rochelle) (Filed on 2/4/2008) (Entered: 02/04/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
02/07/2008	1087 / [2671]	Statement of Non-Opposition re 1068 MOTION for Reconsideration *Notice of Motion and Renewed Motion for Reconsideration; Memorandum of Points and Authorities* filed byMarciano Plata. (Related document(s) 1068) (Specter, Donald) (Filed on 2/7/2008) (Entered: 02/07/ 2008)
02/08/2008	1088 / [2673]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson granting in part 1068 Intervenors' motion for reconsideration and ORDER consolidating proceedings. (tehlc3, COURT STAFF) (Filed on 2/8/2008) (Entered: 02/08/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/12/2008	1093	United States Court of Appeals for the Ninth Circuit Certified JUDGMENT as to re 901 Notice of Appeal: On consideration whereof, it is now here ordered and ad-

Date Filed	Plata # / [Coleman #]	Docket Text
		judged by this Court, that the appeal in this cause be, and hereby is DISMISSED for Lack of Jurisdiction. (tn, COURT STAFF) (Filed on 2/12/2008) (Entered: 02/14/2008)
	* * * *	
02/21/2008	1100	United States Court of Appeals for the Ninth Circuit ORDER: Dismissing Intervenors' Petition for Writ of mandamus as moot. (tn, COURT STAFF) (Filed on 2/21/2008) (Entered: 02/21/2008)
	* * * *	
02/25/2008	1102 / [2689]	Brief *Joint Statement Regarding Discovery Disputes* filed byMarciano Plata. (Rifkin, Lori) (Filed on 2/25/2008) (Entered: 02/25/2008)
	* * * *	
02/26/2008	1107	ORDER approving construction coordination agreement. Signed by Judges Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White, and

Date Filed	Plata # / [Coleman #]	Docket Text
		Claudia Wilken on 02/26/08. (tehlc3, COURT STAFF) (Filed on 2/26/2008) (Entered: 02/26/2008)
	* * * *	
03/04/2008	1116 / [2703]	STIPULATION AND ORDER dismissing intervenor County of Contra Costa. County of Contra Costa terminated. Signed by Judge Thelton E. Henderson, Judge Lawrence Karlton and Judge Stephen Reinhardt on 03/04/08. (rbe, COURT STAFF) (Filed on 3/4/2008) (Entered: 03/04/2008)
	* * * *	
03/06/2008	1119	STATUS REPORT *Receiver's 180-Day Report Re Receiver's Career Executive Assignments* by J. Clark Kelso. (Hector, Kristina) (Filed on 3/6/2008) (Entered: 03/06/2008)
	* * * *	
03/10/2008	1123	ORDER approving information technology coordination agreement. Signed by

Date Filed	Plata # / [Coleman #]	Docket Text
		Judges Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White, and Claudia Wilken on 03/10/08.(tehlc3, COURT STAFF) (Filed on 3/10/2008) (Entered: 03/10/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
03/13/2008	1131 / [2716]	MOTION for Protective Order *Defendants' Notice of Motion and Motion for a Protective Order* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Antonen, Charles) (Filed on 3/13/2008) (Entered: 03/13/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
03/14/2008	1134 / [2721]	REPORT of Rule 26(f) Planning Meeting *Intervenors', Defendants' and Plaintiffs' Proposed Discovery Plans.* (Stegeman, Chad) (Filed on 3/14/2008) (Entered: 03/14/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
03/14/2008	1136	*Receiver's Seventh Quarterly Report* by J. Clark Kelso.

Date Filed	Plata # / [Coleman #]	Docket Text
		(Dodd, Martin) (Filed on 3/14/2008) (Entered: 03/14/2008)
03/14/2008	1137	EXHIBITS re 1136 Status Report *Exhibits to the Receiver's Seventh Quarterly Report* filed byJ. Clark Kelso. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6, # 7 Exhibit 7, # 8 Exhibit 8, # 9 Exhibit 9, # 10 Exhibit 10, # 11 Exhibit 11, # 12 Exhibit 12, # 13 Exhibit 13, # 14 Exhibit 14)(Related document(s) 1136) (Dodd, Martin) (Filed on 3/14/2008) (Entered: 03/14/2008)
03/18/2008	1138 / [2726]	ORDER setting initial disclosure deadline for intervenors and requiring supplemental joint statement re: discovery plan. Signed by Judge John F. Moulds on 03/18/08. (tehlc3, COURT STAFF) (Filed on 3/18/2008) (Entered: 03/18/2008)
03/18/2008	1139 / [2728]	ORDER by Judges Stephen Reinhardt, Lawrence K.

Date Filed	Plata # / [Coleman #]	Docket Text
		Karlton, and Thelton E. Henderson denying 1124 County Intervenors' motion to modify February 8, 2008 order. (tehlc3, COURT STAFF) (Filed on 3/18/2008) (Entered: 03/18/2008)
03/18/2008	1140 / [2727]	Second MOTION for Protective Order filed by Arnold Schwarzenegger. (Attachments: # 1 Supplement Protective Order, # 2 Supplement Declaration of Lisa Tillman in Support of Motion for Protective Order, # 3 Supplement Proof of Service)(Antonen, Charles) (Filed on 3/18/2008) (Entered: 03/18/2008)
03/24/2008	1141 / [2732]	ORDER modifying 1138 Order setting initial disclosure deadline for intervenors and requiring supplemental joint statement re: discovery plan. Signed by Judge John F. Moulds on 03/24/08. (tehlc3, COURT STAFF) (Filed on 3/24/2008) (Entered: 03/24/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
03/26/2008	1143 / [2734]	Memorandum in Opposition re 1140 Second MOTION for Protective Order filed by-Marciano Plata. (Rifkin, Lori) (Filed on 3/26/2008) (Entered: 03/26/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/01/2008	1151	ORDER approving Chief Executive Officer pilot program coordination agreement. Signed by Judges Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White, and Claudia Wilken on 04/01/08. (tehlc3, COURT STAFF) (Filed on 4/1/2008) (Entered: 04/01/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/02/2008	1153	NOTICE by J. Clark Kelso *Receiver's Supplemental Application No. 4 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* (Dodd, Martin) (Filed on 4/2/2008) (Entered: 04/02/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
04/02/2008	1157	United States Court of Appeals for the Ninth Circuit Certified ORDER as to re 1009 Notice of Appeal: GRANTING Appellants' Unopposed Motion for Voluntary Dismissal Under Federal Rule of Appellate Procedure 42(b) of Appeal No. 07-17284 Pursuant to Signed Dismissal Agreement. (tn, COURT STAFF) (Filed on 4/2/2008) (Entered: 04/03/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/14/2008	1160 / [2753]	ORDER re: 1120 Joint list of disputed documents. Plaintiffs' motion to compel documents for which attorney-client privilege was claimed is granted in part and denied in part. Signed by Judge John F. Moulds on 04/14/08. (Attachment: # 1 Defendants' preliminary names list) (tehlc3, COURT STAFF) (Filed on 4/14/2008) (Entered: 04/14/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
04/14/2008	1161	Reply Memorandum *Receiver's Supplemental Reply Memorandum in Support of Motion for Waiver of State Law re Physician Clinical Competency Determinations* filed byJ. Clark Kelso. (Dodd, Martin) (Filed on 4/14/2008) (Entered: 04/14/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/17/2008	1164	Statement of Non-Opposition re 1153 Notice (Other), Notice (Other) *Non-Opposition to Receiver's Supplemental Application No. 4* filed byMarciano Plata. (Related document(s) 1153) (Fama, Steven) (Filed on 4/17/2008) (Entered: 04/17/2008)
04/18/2008	1165 / [2763]	MOTION to Compel *the Production of the OIG's Unredacted Report re: Scott Thomas* filed by Marciano Plata. (Whelan, Amy) (Filed on 4/18/2008) (Entered: 04/18/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/18/2008	1169	Statement of Non-Opposition *Defendants' Statement of Non-Opposition to Receiver's Supplemental Application No. 4 for Order Waiving State Contracting Statutes, Regulations and Procedures, and Approving Receiver's Substitute Procedures for Bidding and Award of Contracts Necessary for the Design, Development and Implementation of the Strategic Offender Management System* filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Lewis, Kyle) (Filed on 4/18/2008) (Entered: 04/18/2008)
04/21/2008	1170 / [2767]	MOTION for Reconsideration *Request for Reconsideration by the Three-Judge Court of Magistrate Judges April 14, 2008 Ruling or, Alternatively, Request for Stay of Order (E.D. L.R. 72-303)* filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 4/21/2008) (Entered: 04/21/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
04/23/2008	1175	ORDER Granting Receiver's Supplemental Application No. 4 For Order Waiving State Contracting Statutes, Regulations And Procedures, Approving Receiver's Substitute Procedure For Bidding And Award of Contracts re 1153 Notice (Other), Notice (Other) filed by J. Clark Kelso. Signed by Judge Thelton E. Henderson on 4/22/08. (fj, COURT STAFF) (Filed on 4/23/2008) (Entered: 04/23/2008)
04/23/2008	1176 / [2773]	Memorandum in Opposition re 1165 MOTION to Compel *the Production of the OIG's Unredacted Report re: Scott Thomas* filed byOffice of the Inspector General. (Attachments: # 1 Affidavit Barbara L. Sheldon in Support of OIG Opposition to Motion to Compel)(Colson, Tamara) (Filed on 4/23/2008) (Entered: 04/23/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/25/2008	1179 / [2777]	ORDER lifting discovery stays and setting discovery deadlines. Status conference set for 05/30/08 at 1:30 PM. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 04/25/08. (tehlc3, COURT STAFF) (Filed on 4/25/2008) (Entered: 04/25/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/25/2008	1181 / [2778]	NOTICE by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger re 1152 Order *Joint Statement Regarding Defendants' Motion for a Protective Order* (Antonen, Charles) (Filed on 4/25/2008) (Entered: 04/25/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
04/28/2008	1184 / [2781]	REPORT of Rule 26(f) Planning Meeting *JOINT SUPPLEMENTAL DISCOVERY STATEMENT PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE 26(f).* (Stegeman, Chad) (Filed on 4/28/2008) (Entered: 04/28/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
		* * * *
05/05/2008	1190	Reply Memorandum *In Support of Motion for Waiver of State law Regarding Physician Clinical Competency Determinations* filed byCalifornia State Personnel Board. (Tigno, Fiel) (Filed on 5/5/ 2008) (Entered: 05/05/2008)
		* * * *
05/09/2008	1194 / [2787]	Memorandum in Opposition re 1170 MOTION for Reconsideration *Request for Reconsideration by the Three-Judge Court of Magistrate Judges April 14, 2008 Ruling or, Alternatively, Request for Stay of Order (E.D. L.R. 72-303)* MOTION for Reconsideration *Request for Reconsideration by the Three-Judge Court of Magistrate Judges April 14, 2008 Ruling or, Alternatively, Request for Stay of Order (E.D. L.R. 72-303)* filed byMarciano Plata. (Rifkin, Lori) (Filed on 5/9/2008) (Entered: 05/09/ 2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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05/12/2008	1196	United States Court of Appeals for the Ninth Circuit ORDER as to re 1045 Notice of Appeal: Granting Appellee's Motion to Dismiss this Appeal for lack of jurisdiction. (tn, COURT STAFF) (Filed on 5/12/2008) (Entered: 05/13/2008)

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05/16/2008	1202 / [2792]	Reply to Opposition re 1170 MOTION for Reconsideration *Request for Reconsideration by the Three-Judge Court of Magistrate Judges April 14, 2008 Ruling or, Alternatively, Request for Stay of Order (E.D. L.R. 72-303)* MOTION for Reconsideration *Request for Reconsideration by the Three-Judge Court of Magistrate Judges April 14, 2008 Ruling or, Alternatively, Request for Stay of Order (E.D. L.R. 72-303)* filed byArnold Schwarzenegger. (Mello, Paul) (Filed on 5/16/2008) (Entered: 05/16/ 2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
05/23/2008	1205	ORDER granting in part and denying in part 645 Receiver's motion for waiver of state law regarding physician clinical competency determinations. Signed by Judge Thelton E. Henderson on 05/23/08. (tehlc3, COURT STAFF) (Filed on 5/23/2008) (Entered: 05/23/2008)
05/27/2008	1206 / [2799]	ORDER by Judge John F. Moulds granting 1165 Motion to compel production of Office of Inspector General's unredacted report. (tehlc3, COURT STAFF) (Filed on 5/27/2008) (Entered: 05/27/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/27/2008	1210 / [2800]	NOTICE by Arnold Schwarzenegger *JOINT STATEMENT REGARDING ADDITIONAL DISCOVERY DISPUTE* (Mello, Paul) (Filed on 5/27/2008) (Entered: 05/27/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
05/29/2008	1216 / [2805]	ORDER re: 1120 Joint list of disputed documents. Plaintiffs' motion to compel documents for which deliberative process privilege was claimed is granted. Signed by Judge John F. Moulds on 05/29/08. (tehlc3, COURT STAFF) (Filed on 5/29/2008) (Entered: 05/29/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/30/2008	1217 / [2807]	Minute Entry: Three-Judge Court Status Conference held (in SF) on 5/30/2008 before Judge Thelton E. Henderson, Judge Lawrence Karlton and Judge Stephen Reinhardt. (Court Reporter: Kathy Wyatt) (rbe, COURT STAFF) (Date Filed: 5/30/2008) (Entered: 05/30/2008)
05/30/2008	1218 / [2806]	ORDER allowing public release of settlement documents. Signed by Judge Thelton E. Henderson, on behalf of the three-judge court, on 05/30/08. (tehlc3, COURT STAFF) (Filed on 5/30/2008) (Entered: 05/30/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
05/30/2008	1219 / [2808]	ORDER setting status conference and trial date and ORDER staying discovery. Signed by Judge Thelton E. Henderson, on behalf of the three-judge court, on 05/30/08. (tehlc3, COURT STAFF) (Filed on 5/30/2008) (Entered: 05/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/04/2008	1225 / [2812]	MOTION for Reconsideration re 1216 Order *Defendants' Request for Reconsideration by the Three Judge Court of Magistrate Judge's May 29, 2008 Ruling or, Alternatively, Request for Stay or Order* filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 6/4/2008) (Entered: 06/04/2008)
06/05/2008	1226 / [2813]	ORDER re: role of Receiver and Special Master regarding population advisory group. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 06/05/08. (tehlc3, COURT STAFF) (Filed on 6/5/2008) (Entered: 06/05/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
06/06/2008	1227	ORDER appointing advisory board. Signed by Judge Thelton E. Henderson on 06/06/ 08. (tehlc3, COURT STAFF) (Filed on 6/6/2008) (Entered: 06/06/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/06/2008	1229	NOTICE by J. Clark Kelso *Notice of Filing of the Receiver's Turnaround Plan of Action* (Dodd, Martin) (Filed on 6/6/2008) (Entered: 06/06/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
06/09/2008	1236 / [2814]	JOINT CASE MANAGEMENT STATEMENT *Defendants, Plaintiffs, And Intervenors Joint Status Conference Statement* filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 6/9/2008) (Entered: 06/09/2008)
06/10/2008	1237	STIPULATION AND ORDER re merger of medical health care at Pelican Bay State Prison. Signed by Judge Thelton E. Henderson

Date Filed	Plata # / [Coleman #]	Docket Text
		on 06/06/08. (rbe, COURT STAFF) (Filed on 6/10/2008) (Entered: 06/10/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/12/2008	1240	NOTICE by J. Clark Kelso *Receiver's Supplemental Application No. 5 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* (Dodd, Martin) (Filed on 6/12/2008) (Entered: 06/12/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
06/16/2008	1243	NOTICE by J. Clark Kelso *Receiver's Supplemental Application No. 6 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* (Dodd, Martin) (Filed on 6/16/2008) (Entered: 06/16/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/16/2008	1245	ORDER approving 1229 Receiver's Turnaround Plan of Action. Signed by Judge Thelton E. Henderson on 06/16/08. (tehlc3, COURT STAFF) (Filed on 6/16/2008) (Entered: 06/16/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/17/2008	1246 / [2825]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1170 Motion for reconsideration of 1160 the magistrate judge's April 14, 2008 order. (tehlc3, COURT STAFF) (Filed on 6/17/2008) (Entered: 06/17/2008)
06/17/2008	1248	NOTICE by J. Clark Kelso *Notice of Filing of Receiver's Eighth Quarterly Report* (Dodd, Martin) (Filed on 6/17/2008) (Entered: 06/17/2008)
06/17/2008	1249	EXHIBITS re 1248 Notice (Other) *Exhibits to Receiver's Eighth Quarterly Report* filed byJ. Clark Kelso. (Attachments: # 1 Exhibit 1, # 2

Date Filed	Plata # / [Coleman #]	Docket Text
		Exhibits 2 to 5, # 3 Exhibit 6-part 1, # 4 Exhibit 6-part 2, # 5 Exhibit 6-part 3, # 6 Exhibits 7 to 9, # 7 Exhibit 10-part 1, # 8 Exhibit 10-part 2, # 9 Exhibits 11 to 14) (Related document(s) 1248) (Dodd, Martin) (Filed on 6/17/2008) (Entered: 06/17/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/19/2008	1252	Transcript of Proceedings held on 5/30/08, before Judge Three-Judge-Panel. Court Reporter/Transcriber Katherine Wyatt, Telephone number 415-487-9834. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 busi-

Date Filed	Plata # / [Coleman #]	Docket Text
		ness days from date of this filing. Release of Transcript Restriction set for 9/15/2008. (kpw, COURT STAFF) (Filed on 6/19/2008) (Entered: 06/19/2008)
		* * * *
06/20/2008	1258 / [2832]	ORDER by Judge John F. Moulds granting in part and denying in part 1131 1140 Defendants' Motion for Protective Order. (tehlc3, COURT STAFF) (Filed on 6/20/2008) (Entered: 06/20/2008)
		* * * *
06/20/2008	1262	NOTICE by J. Clark Kelso *Receiver's Report re Physician Clinical Competency Determination Policies and Procedures* (Dodd, Martin) (Filed on 6/20/2008) (Entered: 06/20/2008)
		* * * *
06/23/2008	1267	NOTICE by J. Clark Kelso *Correction to Receiver's Re-*

Date Filed	Plata # / [Coleman #]	Docket Text
		port re Physician Clinical Compentency Determination Policies and Procedures (Dodd, Martin) (Filed on 6/23/2008) (Entered: 06/23/2008)

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06/25/2008	1274 / [2838]	Reply to Opposition re 1225 MOTION for Reconsideration re 1216 Order *Defendants' Request for Reconsideration by the Three-Judge Court of Magistrate Judge's May 29, 2008 Ruling or, Alternatively, Request for Stay or Order* MOTION for Reconsideration re 1216 Order *Defendants' Request for Reconsideration by the Three-Judge Court of Magistrate Judge's May 29, 2008 Ruling or, Alternatively, Request for Stay or Order Defendants Reply To Plaintiffs Opposition To Defendants Request For Reconsideration By The Three-Judge Court Of Magistrate Judges May 29, 2008 Ruling Or, Alternatively, Request For Stay Of Order* filed byArnold Schwarzenegger.

Date Filed	Plata # / [Coleman #]	Docket Text
		(Mello, Paul) (Filed on 6/25/2008) (Entered: 06/25/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/27/2008	1284 / [2856]	Minute Entry: Three-Judge Court Status Conference held (in SF) before Judges Thelton E. Henderson, Lawrence Karlton and Stephen Reinhardt. (Court Reporter: Joan Columbini) (rbe, COURT STAFF) (Date Filed: 6/27/2008) (Entered: 06/27/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
06/27/2008	1286	Statement of Non-Opposition re 1240 Notice (Other), Notice (Other) *Defendants' Statement of Non-Opposition to Receiver's Supplemental Application No. 5 Waiving State Law* filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Related document(s) 1240) (Mello, Paul) (Filed on 6/27/2008) (Entered: 06/27/ 2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
06/30/2008	1288	NOTICE by J. Clark Kelso *Receiver's Reply in Support of Supplemental Application No. 5 for Order Waiving State Contracting Statutes, Regulations and Procedures, Approving Receiver's Substitute Procedure for Bidding and Award of Contracts* (Dodd, Martin) (Filed on 6/30/2008) (Entered: 06/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/01/2008	1292	ORDER granting 1240 Receiver's supplemental application no. 5 for order waiving state contracting statutes, etc. Signed by Judge Thelton E. Henderson on 07/01/08. (tehlc3, COURT STAFF) (Filed on 7/1/2008) (Entered: 07/01/2008)
07/02/2008	1293	ORDER granting 1243 Receiver's supplemental application no. 6 for order waiving state contracting statutes, etc. Signed by Judge Thelton E. Henderson on

Date Filed	Plata # / [Coleman #]	Docket Text
		07/02/08. (tehlc3, COURT STAFF) (Filed on 7/2/2008) (Entered: 07/02/2008)
07/02/2008	1294 / [2859]	ORDER for pretrial preparation for three-judge court proceedings. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 07/02/08. (tehlc3, COURT STAFF) (Filed on 7/2/2008) (Entered: 07/02/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/08/2008	1300 / [2862]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1225 Motion for reconsideration of 1216 the magistrate judge's May 29, 2008 order. (tehlc3, COURT STAFF) (Filed on 7/8/2008) (Entered: 07/08/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/09/2008	1302	ORDER approving, with modifications, proposed policies regarding physician clinical competency (attached as Exhibit 1 to 1263).

Date Filed	Plata # / [Coleman #]	Docket Text
		Signed by Judge Thelton E. Henderson on 07/09/08. (tehlc3, COURT STAFF) (Filed on 7/9/2008) (Entered: 07/09/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
07/09/2008	1304 / [2869]	Memorandum in Opposition *Defendants' Statement in Opposition to Plaintiffs' Request for Inspection* filed by- James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 7/9/2008) (Entered: 07/09/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
07/10/2008	1311 / [2873]	RESPONSE to re 1294 Order *Plata Defendants Statement In Response To Three-Judge Courts July 2, 2008 Order Requiring Defendants Showing To File Motion For Summary Judgment* by Arnold Schwarzenegger. (Mello, Paul) (Filed on 7/10/2008) (Entered: 07/10/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
07/11/2008	1312 / [2874]	ORDER on 1305 discovery dispute regarding Plaintiffs' third request for inspection. Signed by Judge John F. Moulds on 07/11/08. (tehlc3, COURT STAFF) (Filed on 7/11/2008) (Entered: 07/11/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/11/2008	1314	Transcript of Proceedings held on June 27, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this

Date Filed	Plata # / [Coleman #]	Docket Text
		filing. Release of Transcript Restriction set for 10/6/2008. (Columbini, Joan) (Filed on 7/11/2008) (Entered: 07/11/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/17/2008	1324 / [2879]	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuitas to re 1160 Order & re 1246 Order on Motion for Reconsideration Filed by Defendants Michael C. Genest, Governor Arnold Schwarzenegger & Matthew Cate - [Filing Fee: $455.00, Receipt Number 34611021428]. (tn, COURT STAFF) (Filed on 7/17/2008) (Entered: 07/18/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/21/2008	1326	STIPULATION *and Proposed Order* by Marciano Plata. (Norman, Sara) (Filed on 7/21/2008) (Entered: 07/21/2008)
07/21/2008	1327 / [2885]	MOTION to Compel *Certain Defendants' Depositions (to be heard by Mag. Judge*

Date Filed	Plata # / [Coleman #]	Docket Text
		Moulds in E.D. Cal.) filed by Marciano Plata. Motion Hearing set for 8/7/2008 11:00 AM. (Morris, Maria) (Filed on 7/21/2008) (Entered: 07/21/2008)
07/21/2008	1328 / [2886]	MOTION to Compel *Supplemental Responses and Production (to be heard by Mag. Judge Moulds in E.D. Cal.)* filed by Marciano Plata. Motion Hearing set for 8/7/2008 11:00 AM. (Morris, Maria) (Filed on 7/21/2008) (Entered: 07/21/2008)
07/21/2008	1329 / [2887]	STIPULATION re 1328 MOTION to Compel *Supplemental Responses and Production (to be heard by Mag. Judge Moulds in E.D. Cal.) and [Proposed] Order Shortening Time* by Marciano Plata. (Morris, Maria) (Filed on 7/21/2008) (Entered: 07/21/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/23/2008	1335 / [2891]	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to the Court's re 1216 Or-

Date Filed	Plata # / [Coleman #]	Docket Text
		der & re 1300 Order on Motion for Reconsideration Filed by Defendants Michael C. Genest, Arnold Schwarzenegger & Matthew Cate - [Filing Fee: $455.00, Receipt Number 34611021614]. (tn, COURT STAFF) (Filed on 7/23/2008) (Entered: 07/24/2008)
		* * * *
07/25/2008	1336 / [2897]	STIPULATION *Stipulation and Proposed Order Regarding Expert Discovery and Evidence* by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 7/25/2008) (Entered: 07/25/2008)
		* * * *
07/29/2008	1340 / [2901]	ORDER denying 1336 Stipulation to extend expert discovery deadlines. Signed by Judge John F. Moulds on 07/29/08. (tehlc3, COURT STAFF) (Filed on 7/29/2008) (Entered: 07/29/2008)
07/30/2008	1341 /	STIPULATION *and Proposed Order Regarding Ex-*

Date Filed	Plata # / [Coleman #]	Docket Text
	[2902]	*pert Discovery and Evidence* by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C)(Mello, Paul) (Filed on 7/30/2008) (Entered: 07/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/31/2008	1343 / [2903]	MOTION to Compel filed by Marciano Plata. Motion Hearing set for 8/7/2008 11:00 AM. (Attachments: # 1 Proposed Order)(Evenson, Rebekah) (Filed on 7/31/2008) (Entered: 07/31/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/01/2008	1347	STATUS REPORT *Re Physician Clinical Competency Determination Policies and Procedures* by J. Clark Kelso. (Dodd, Martin) (Filed on 8/1/2008) (Entered: 08/01/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/01/2008	1349 / [2906]	MOTION to Compel *depositions* filed by Marciano Plata. Motion Hearing set for

Date Filed	Plata # / [Coleman #]	Docket Text
		8/7/2008 11:00 AM. (Evenson, Rebekah) (Filed on 8/1/2008) (Entered: 08/01/2008)
08/01/2008	1350 / [2907]	Declaration of Evenson in Support of 1349 MOTION to Compel *depositions* filed byMarciano Plata. (Attachments: # 1 Exhibit A-J, # 2 Exhibit K-T, # 3 Exhibit U-V)(Related document(s) 1349) (Evenson, Rebekah) (Filed on 8/1/2008) (Entered: 08/01/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/01/2008	1358 / [2913]	Brief re 1328 MOTION to Compel *Supplemental Responses and Production (to be heard by Mag. Judge Moulds in E.D. Cal.) Joint Statement* filed byMarciano Plata. (Related document(s) 1328) (Morris, Maria) (Filed on 8/1/2008) (Entered: 08/01/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/05/2008	1365 / [2916]	Memorandum in Opposition re 1343 MOTION to Compel *Defendants' Opposition to*

Date Filed	Plata # / [Coleman #]	Docket Text
		Plaintiffs' Motion to Compel Discovery Responses filed byArnold Schwarzenegger. (Jacob, Renju) (Filed on 8/5/ 2008) (Entered: 08/05/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/06/2008	1367	ORDER re: physician clinical competency policies and implementation plan. Joint status report due by 09/15/08. Signed by Judge Thelton E. Henderson on 08/06/08. (tehlc3, COURT STAFF) (Filed on 8/6/2008) (Entered: 08/06/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/11/2008	1370 / [2933]	*DEFENDANTS' STATEMENT IN RESPONSE TO COURT'S INQUIRIES* Filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 8/11/2008) (Entered: 08/11/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/12/2008	1374 / [2937]	MOTION for Sanctions *for Improper Withholding of Non-Privileged Documents* filed by Marciano Plata.

Date Filed	Plata # / [Coleman #]	Docket Text
		(Morris, Maria) (Filed on 8/12/2008) (Entered: 08/12/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/14/2008	1385 / [2946]	ORDER by Judge John F. Moulds granting 1327 , 1349 Motion to Compel certain depositions and denying 1328 Motion to Compel supplemental responses and production. (tehlc3, COURT STAFF) (Filed on 8/14/2008) (Entered: 08/14/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/14/2008	1390	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to the Court's re 1342 Order & re 1273 Order - [Filing Fee: $455.00, Receipt Number 34611022393] Filed by Petitioner/Appellant Medical Development International. (tn, COURT STAFF) (Filed on 8/14/2008) (Entered: 08/15/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/18/2008	1393 / [2955]	Reply to Opposition re 1374 MOTION for Sanctions *for Improper Withholding of Non-Privileged Documents Defendants' Opposition to Plaintiffs' Motion for Discovery Sanctions Concerning Format of Documents* filed byArnold Schwarzenegger. (Jacob, Renju) (Filed on 8/18/2008) (Entered: 08/18/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/19/2008	1403 / [2962]	RESPONSE in Support re 1374 MOTION for Sanctions *for Improper Withholding of Non-Privileged Documents* filed byMarciano Plata. (Morris, Maria) (Filed on 8/19/2008) (Entered: 08/19/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/19/2008	1406 / [2965]	Memorandum in Opposition re 1374 MOTION for Sanctions *for Improper Withholding of Non-Privileged Documents* filed byJames E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (East,

Date Filed	Plata # / [Coleman #]	Docket Text
		Rochelle) (Filed on 8/19/2008) (Entered: 08/19/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/19/2008	1409	United States Court of Appeals for the Ninth Circuit ORDER as to re 1291 Notice of Appeal: Dismissing Appeal for Lack of Jurisdiction. (tn, COURT STAFF) (Filed on 8/19/2008) (Entered: 08/20/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
08/21/2008	1411 / [2970]	ORDER by Judge John F. Moulds granting in part 1374 Plaintiffs' Motion for Sanctions. (tehlc3, COURT STAFF) (Filed on 8/21/2008) (Entered: 08/21/2008)
08/21/2008	1412 / [2971]	MOTION for Discovery *Motion for Order Compelling Depositions of Certain Legislator Intervenors* filed by Marciano Plata. (Sangster, Edward) (Filed on 8/21/2008) (Entered: 08/21/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/25/2008	1420 / [2980]	Memorandum in Opposition *to re 1389 Defs' Request for Reconsideration of Magistrate Judge's Ruling Requiring Depositions (E.D. L.R. 72-303)* Filed by Marciano Plata. (Evenson, Rebekah) (Filed on 8/25/2008) (Entered: 08/25/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/28/2008	1433 / [2992]	*Joint Statement Pursuant to August 26, 2008 Order* by Marciano Plata. (Morris, Maria) (Filed on 8/28/2008) (Entered: 08/28/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
08/29/2008	1436 / [2998]	NOTICE by Arnold Schwarzenegger *Defendants Request For Evidence From The California Prison Health Care Receivership Corporation* (Mello, Paul) (Filed on 8/29/2008) (Entered: 08/29/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
09/02/2008	1438 / [2999]	Reply Memorandum *Defendants' Reply in Support of Request for Reconsideration*

Date Filed	Plata # / [Coleman #]	Docket Text
		by Three-Judge Court filed byArnold Schwarzenegger. (Mello, Paul) (Filed on 9/2/2008) (Entered: 09/02/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/02/2008	1440 / [3000]	Reply to Opposition *To Motion for Clarafication of Order for Pretrial Preparation* filed byCalifornia Correctional Peace Officers Association, California Department of Corrections, Butte County Sheriff- Coroner Perry L. Reniff, Contra Costa County Sheriff Warren Rupf, Dave Cogdill. (Attachments: # 1 Affidavit Declaration of Kimberly Hall Barlow, # 2 Affidavit Declaration of Anne Keck, # 3 Affidavit Declaration of Theresa Fuentes)(Barlow, Kimberly) (Filed on 9/2/2008) (Entered: 09/02/2008)
09/02/2008	1441 / [3002]	MOTION for Reconsideration re 1435 Order *Defendants Request for Reconsideration by the Three-Judge Court of Magistrate Judges August 29, 2008 Ruling or,*

Date Filed	Plata # / [Coleman #]	Docket Text
		Alternatively, Request for filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/2/2008) (Entered: 09/02/ 2008)
09/02/2008	1442	NOTICE by J. Clark Kelso *Receiver's Supplemental Application No. 7 For Order Waiving State Contracting Statutes, Regulations and Procedures and Authorizing Receiver To Enter into Contract for Quality Measurement Technical Assistance* (Dodd, Martin) (Filed on 9/2/2008) (Entered: 09/02/ 2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
09/03/2008	1446 / [3004]	*Memorandum of Points and Authorities In Support of Motion for Order Compelling Depositions of Certain Legislator Intervenors and Cross-Motion for Protective Order* Filed by Marciano Plata. (Sangster, Edward) (Filed on 9/3/2008) (Entered: 09/03/ 2008)
09/03/2008	1447 /	MOTION for Protective Order filed by Todd Spitzer.

Date Filed	Plata # / [Coleman #]	Docket Text
	[3005]	Motion Hearing set for 9/5/2008 01:30 PM. (Attachments: # 1 Affidavit, # 2 Exhibit Exhibits A-J, # 3 Exhibit Exhibit K, # 4 Exhibit Exhibits L-O)(Stegeman, Chad) (Filed on 9/3/2008) (Entered: 09/03/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/05/2008	1450 / [3010]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson re: 1436 Defendants' request for evidence from the California Prison Health Care Receivership Corporation. (tehlc3, COURT STAFF) (Filed on 9/5/2008) (Entered: 09/05/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
09/05/2008	1452 / [3008]	*Plaintiffs' RESPONSE to Defendants' Request for Evidence From California Prison Health Care Receivership Corporation* Filed by Plaintiffs Marciano Plata. (Fama, Steven) (Filed on 9/5/2008) (Entered: 09/05/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
09/05/2008	1453 / [3009]	Declaration of Steven Fama in Support of re 1452 *Plaintiffs' Response to Defendants' Request For Evidence From The California Prison Health Care Receivership Corporation* Filed by Plaintiffs Marciano Plata. (Attachments: # 1 Exhibit) (Related document(s) 1452) (Fama, Steven) (Filed on 9/5/2008) (Entered: 09/05/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/05/2008	1455 / [3015]	*STATEMENT Re Cate Discovery Dispute Re Mathew Cate Deposition* Filed by Plaintiffs Marciano Plata. (Attachments: #(1) Affidavit Specter Declaration iso Motion to Compel, #(2) Exhibit A, #(3) Exhibit B-D). (Evenson, Rebekah) (Filed on 9/5/2008) (Entered: 09/05/2008)
09/05/2008	1456 / [3016]	*Defendants' Opposition to Plaintiffs' Motion to Compel the Privileged Deposition Testimony of Matthew Cate* Filed by Defendants Mat-

Date Filed	Plata # / [Coleman #]	Docket Text
		thew Cate. (Lewis, Kyle) (Filed on 9/5/2008) (Entered: 09/05/2008)

* * * *

09/08/2008	1458 / [3019]	ORDER by Judge John F. Moulds granting in part and denying in part 1412 Plaintiffs' motion for order compelling deposition of certain legislative intervenors and 1414 Legislative Intervenors' motion for protective order. Depositions of Senator George Runner and Assemblyman Todd Spitzer shall be taken. Depositions of Senator David Codgill and Assemblyman Michael Villines shall not be taken. (tehlc3, COURT STAFF) (Filed on 9/8/2008) (Entered: 09/08/ 2008)

* * * *

09/09/2008	1460 / [3021]	Memorandum in Opposition re 1441 MOTION for Reconsideration re 1435 Order *Defendants Request for Reconsideration by the Three-Judge Court of Magistrate Judges August 29, 2008 Rul-*

Date Filed	Plata # / [Coleman #]	Docket Text
		ing or, Alternatively, Request for MOTION for Reconsideration re 1435 Order *Defendants Request for Reconsideration by the Three-Judge Court of Magistrate Judges August 29, 2008 Ruling or, Alternatively, Request for* filed byMarciano Plata. (Morris, Maria) (Filed on 9/9/2008) (Entered: 09/09/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/09/2008	1463	United States Court of Appeals for the Ninth Circuit ORDER as to re 1324 Notice of Appeal. (tn, COURT STAFF) (Filed on 9/9/2008) (Entered: 09/10/2008)
09/09/2008	1466	United States Court of Appeals for the Ninth Circuit ORDER as to re 1335 Notice of Appeal filed by Defendants Arnold Schwarzenegger & Michael C. Genest. (tn, COURT STAFF) (Filed on 9/9/2008) (Entered: 09/10/2008)
09/10/2008	1462 /	ORDER by Judge John F. Moulds granting 1455 Plain-

Date Filed	Plata # / [Coleman #]	Docket Text
	[3023]	tiffs' Motion to Compel deposition testimony of Matthew Cate. (tehlc3, COURT STAFF) (Filed on 9/10/2008) (Entered: 09/10/2008)
09/10/2008	1464 / [3024]	MOTION for Reconsideration re 1462 Order on Motion to Compel *Defendants' Request for Reconsideration by the Three-Judge Court of Magistrate Judge's Ruling Requiring CDCR Secretary Cate to Submit to Deposition Questions of Privileged Matters; Request for Stay of Order (E.D.L.R. 72-303)* filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/10/2008) (Entered: 09/10/2008)
		* * * *
09/11/2008	1469 / [3028]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1464 Defendants' Motion for Reconsideration of the magistrate judge's September 10, 2008 order re: the deposition of Matthew Cate. (tehlc3,

Date Filed	Plata # / [Coleman #]	Docket Text
		COURT STAFF) (Filed on 9/11/2008) (Entered: 09/11/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/15/2008	1471 / [3032]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson granting in part and denying in part 1389 Defendants' Motion for Reconsideration of the magistrate judge's August 14, 2008 order. The motion is granted as to the depositions of Governor Arnold Schwarzenegger and Chief of Staff Susan Kennedy, and denied as to the deposition of Deputy Cabinet Secretary Robert Gore. (tehlc3, COURT STAFF) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1472	NOTICE by J. Clark Kelso *Notice of Filing of Receiver's Ninth Quarterly Report and Receiver's Ninth Quarterly Report* (Attachments: # 1 Appendix Table of Contents, # 2 Appendix Appendix 1, # 3 Appendix Appendix 2, # 4

Date Filed	Plata # / [Coleman #]	Docket Text
		Appendix Appendix 3)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1473	NOTICE by J. Clark Kelso re 1472 Notice (Other), Notice (Other) *Appendices 4 through 8 to Receiver's Ninth Quarterly Report* (Attachments: # 1 Appendix 5, # 2 Appendix 6, # 3 Appendix 7, # 4 Appendix 8)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1474	NOTICE by J. Clark Kelso re 1473 Notice (Other), Notice (Other), 1472 Notice (Other), Notice (Other) *Apendices 9 through 15 to Receiver's Ninth Quarterly Report* (Attachments: # 1 Appendix 10, # 2 Appendix 11, # 3 Appendix 12, # 4 Appendix 13, # 5 Appendix 14, # 6 Appendix 15)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1475	NOTICE by J. Clark Kelso re 1473 Notice (Other), Notice (Other), 1474 Notice (Other), Notice (Other), 1472

Date Filed	Plata # / [Coleman #]	Docket Text
		Notice (Other), Notice (Other) *Appendices 16 through 18 of Receiver's Ninth Quarterly Report* (Attachments: # 1 Appendix 17, # 2 Appendix 18)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/15/2008	1477	NOTICE by J. Clark Kelso re 1473 Notice (Other), Notice (Other), 1475 Notice (Other), Notice (Other), 1474 Notice (Other), Notice (Other), 1472 Notice (Other), Notice (Other) *Appendices 19, 22 through 29 of Receiver's Ninth Quarterly Report* (Attachments: # 1 Appendix 22, # 2 Appendix 23, # 3 Appendix 24, # 4 Appendix 25, # 5 Appendix 26, # 6 Appendix 27, # 7 Appendix 28, # 8 Appendix 29)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1478 / [3033]	*Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudica-*

Date Filed	Plata # / [Coleman #]	Docket Text
		tion Diled by Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1479 / [3034]	*Defendants' Memorandum of Points and Authorities in Support of re 1478 Motions for Dismissal or, Alternatively, for Summary Judgment or Summary Adjudication* Filed by Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1480	NOTICE by J. Clark Kelso re 1472 Notice (Other), Notice (Other) *Appendices 20 and 21 to Recevier's Ninth Quarterly Report* (Attachments: # 1 Appendix 21)(Dodd, Martin) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1481 / [3035]	Declaration in Support of 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication Declaration of*

Date Filed	Plata # / [Coleman #]	Docket Text
		Paul B. Mello in Support of Defendants' Motions for Dismissal or, Alternatively, for Summary Judgment or Summary Adjudication filed byArnold Schwarzenegger. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Related document(s) 1478) (Mello, Paul) (Filed on 9/15/2008) (Entered: 09/15/2008)
09/15/2008	1482 / [3036]	Declaration of N. Grannis in Support of 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication Declaration of N. Grannis in Support of Defendants' Motion to Dismiss, or In the Alternative, Motion for Summary Judgment* filed byArnold Schwarzenegger. (Attachments: # 1 Exhibit A-K)(Related document(s) 1478) (Mello, Paul) (Filed on 9/15/2008) (Entered: 09/15/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/15/2008	1494 / [3038]	Brief re 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication Defendants' Seperate Statement of Undisputed Facts in Support of Motions for Dismissal, or, Alternatively, Summary Judgment* filed byArnold Schwarzenegger. (Related document(s) 1478) (Mello, Paul) (Filed on 9/15/2008) (Entered: 09/15/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/15/2008	1497 / [3037]	Declaration of Lisa Tillman in Support of 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMatthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A)(Related document(s) 1478) (Tama, Samantha) (Filed on 9/15/2008) (Entered: 09/15/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
09/17/2008	1498 / [3046]	ERRATA re 1494 Brief, *Errata to Defendants Separate Statement of Undisputed Facts in Support of Motions for Dismissal, or, Alternatively, Summary Judgment or Summary Adjudication, Filed on September 15, 2008* by Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/17/2008) (Entered: 09/17/2008)
09/18/2008	1499	ORDER granting 1442 Receiver's supplemental application no. 7 for order waiving state contracting statutes, etc. Signed by Judge Thelton E. Henderson on 09/18/08. (tehlc3, COURT STAFF) (Filed on 9/18/2008) (Entered: 09/18/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/19/2008	1501	STATUS REPORT *Receiver and State Personnel Board's Joint Status Report RE Physician Clinical Competency Determination Policies And Procedures* by J. Clark Kelso. (Dodd, Martin) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		9/19/2008) (Entered: 09/19/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/23/2008	1510	Transcript of Proceedings held on 5-30-08, before Judge Thelton Henderson. Court Reporter/Transcriber Katherine Wyatt, Telephone number 415-487-9834. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 12/19/ 2008. (kpw, COURT STAFF) (Filed on 9/23/2008) (Entered: 09/23/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
09/25/2008	1515 / [3050]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1441 Defendants' Motion for Reconsideration of the magistrate judge's August 29, 2008 order. (tehlc3, COURT STAFF) (Filed on 9/25/2008) (Entered: 09/25/2008)
09/26/2008	1516	Further ORDER re: physician clinical competency policies and implementation plan. Joint status report due on or before 11/21/08. Signed by Judge Thelton E. Henderson on 09/26/08. (tehlc3, COURT STAFF) (Filed on 9/26/2008) (Entered: 09/26/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/29/2008	1522 / [3053]	Memorandum in Opposition *to Defs Mot to Dismiss / Summary Judgment* filed byMarciano Plata. (Evenson, Rebekah) (Filed on 9/29/2008) (Entered: 09/29/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
09/29/2008	1523 / [3062]	RESPONSE to re 1498 Errata, *Defendants' Separate Statement of Facts* by Marciano Plata. (Norman, Sara) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1524 / [3054]	Request for Judicial Notice re 1522 Memorandum in Opposition *to Defs' Motion to Dismiss and/or Motion for Summary Judgment/ Adjudication* filed byMarciano Plata. (Related document(s) 1522) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1525 / [3055]	DECLARATION of Donald Specter in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1526 / [3056]	DECLARATION in Opposition to 1478 MOTION for

Date Filed	Plata # / [Coleman #]	Docket Text
		Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1527 / [3057]	DECLARATION of Dr. Ronald Shansky in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1528 / [3058]	DECLARATION of Doyle Wayne Scott in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan,

Date Filed	Plata # / [Coleman #]	Docket Text
		Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1529 / [3059]	DECLARATION of Arthur Reingold in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1530 / [3060]	DECLARATION of Joseph Lehman in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1531 / [3061]	DECLARATION of Craig Haney, PhD in Opposition to 1478 MOTION for Summary Judgment *Defendants' No-*

Date Filed	Plata # / [Coleman #]	Docket Text
		tice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication filed byMarciano Plata. (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1532 / [3063]	DECLARATION of Dr. Pablo Stewart in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byMarciano Plata. (Attachments: # 1 Exhibit C (through Appendix C), # 2 Exhibit C (through Appendix D), # 3 Exhibit C (through Appendix F)) (Related document(s) 1478) (Whelan, Amy) (Filed on 9/29/2008) (Entered: 09/29/2008)
09/29/2008	1533 / [3064]	DECLARATION of Lisa Ells in Opposition to 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary*

Date Filed	Plata # / [Coleman #]	Docket Text
		Judgment or Summary Adjudication filed byMarciano Plata. (Attachments: # 1 Exhibit Exh. L-Q, # 2 Exhibit Exh. R-S, # 3 Exhibit Exh. T-U, # 4 Exhibit Exh. V-Z, # 5 Exhibit Exh. AA-CC, # 6 Exhibit Exh. DD, # 7 Exhibit Exh. DD-EE, # 8 Exhibit Exh. FF-II)(Related document(s) 1478) (Ells, Lisa) (Filed on 9/29/2008) (Entered: 09/29/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/06/2008	1537 / [3066]	Reply to Opposition re 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byArnold Schwarzenegger. (Mello, Paul) (Filed on 10/6/2008) (Entered: 10/06/2008)
10/06/2008	1538 / [3067]	Declaration of Paul B. Mello in Support of 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or*

Date Filed	Plata # / [Coleman #]	Docket Text
		Summary Adjudication Supplemental Declaration of Paul B. Mello in Support of Defendants' Reply to Plaintiffs' Opposition to Defendants' Motions for Dismissal or, Alternatively, for Summary Judgment or Summary Adjudication filed byArnold Schwarzenegger. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit) (Related document(s) 1478) (Mello, Paul) (Filed on 10/6/2008) (Entered: 10/06/2008)
10/06/2008	1539 / [3068]	OBJECTIONS to re 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication Defendants' Objections to Plaintiffs' Evidence in Opposition to Motions for Dismissal or, Altneratively, Summary Judgment or Summary Adjudication* by Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/6/2008) (Entered: 10/06/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
10/06/2008	1542 / [3070]	Brief re 1478 MOTION for Summary Judgment *Defendants' Notice of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication Defendants' Status Statement Regarding Statement of Undisputed Facts in Support of Motions for Dismissal or, Alternatively, Summary Judgment or Summary Adjudication* filed byArnold Schwarzenegger. (Related document(s) 1478) (Mello, Paul) (Filed on 10/6/2008) (Entered: 10/06/2008)
10/06/2008	1543	Transcript of Proceedings held on 10/06/2008, before Judge Thelton E. Henderson. Court Reporter/ Transcriber Lydia Zinn, Telephone number (415) 531-6587. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Tran-

Date Filed	Plata # / [Coleman #]	Docket Text
		scriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 1/2/2009. (Zinn, Lydia) (Filed on 10/6/2008) (Entered: 10/06/2008)
10/07/2008	1544 / [3071]	Brief re 1539 Objection, *Errata To Defendants Objections To Plaintiffs Evidence In Opposition To Motions For Dismissal Or, Alternatively, Summary Judgment Or Summary Adjudication* filed byArnold Schwarzenegger. (Related document(s) 1539) (Mello, Paul) (Filed on 10/7/2008) (Entered: 10/07/ 2008)
10/07/2008	1545	ORDER approving space coordination agreement. Signed by Judges Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White, and Claudia Wilken on 10/07/08.

Date Filed	Plata # / [Coleman #]	Docket Text
		(tehlc3, COURT STAFF) (Filed on 10/7/2008) (Entered: 10/07/2008)
10/07/2008	1546	ORDER re: Receiver's Construction Oversight Advisory Board and Rehabilitation Services Advisory Council. Signed by Judge Thelton E. Henderson on 10/07/08. (tehlc3, COURT STAFF) (Filed on 10/7/2008) (Entered: 10/07/2008)
10/07/2008	1547 / [3074]	DECLARATION of Evenson in Opposition to 1522 Memorandum in Opposition *to Defs Mot to Dismiss/ Summary Judgment* filed byMarciano Plata. (Related document(s) 1522) (Evenson, Rebekah) (Filed on 10/7/2008) (Entered: 10/07/2008)
10/07/2008	1548 / [3075]	Request for Judicial Notice re 1522 Memorandum in Opposition *to Defs Mot to Dismiss/ Summary Judgment* filed byMarciano Plata. (Related document(s) 1522) (Evenson, Rebekah) (Filed on 10/7/2008) (Entered: 10/07/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
10/13/2008	1554 / [3080]	RESPONSE to *"Plaintiffs' Response to Defendants' Objections to Evidence Submitted in Opposition to Motions for Dismissal or, Alternatively, Summary Judgment or Adjudication"* by Marciano Plata. (Whelan, Amy) (Filed on 10/13/2008) (Entered: 10/13/2008)
10/14/2008	1555	J. Clark Kelso *Receiver's Application for Order Waiving State Statutues, Regulations and Procedures Regarding Salary Grids for Receiver Career Executive Assignments* (Dodd, Martin) (Filed on 10/14/2008) (Entered: 10/14/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1559 / [3085]	MOTION in Limine *Defendants' Motion in Limine No. 10 to Exclude Evidence Re: Suicide Rate in California Prisons* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		10/20/2008) (Entered: 10/20/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1561 / [3087]	MOTION in Limine *Defendants' Motion in Limine No. 11 to Exclude Evidence Re: Desert Institutions* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1564 / [3090]	MOTION in Limine *Defendants' Motion in Limine No. 14 Re: Evidence of Alleged Noncompliance by The Department of Mental Health* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)
10/20/2008	1565 / [3091]	MOTION in Limine *Defendants' Motion in Limine No. 12 to Exclude Report and Testimony of Plaintiffs' Expert James Gilligan and Pablo Stewart* filed by James

Date Filed	Plata # / [Coleman #]	Docket Text
		E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)
10/20/2008	1566 / [3092]	MOTION in Limine *Defendants' Motion in Limine No. 2 to Exclude (a) CCPOA Witnesses and (b) CCPOA Testimony About Housing, Violence, Danger, Security* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1570 / [3096]	MOTION in Limine *Defendants' Motion in Limine No. 5 to Exclude Evidence Re: References to Sentencing Commission and Reform* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1574 / [3100]	MOTION in Limine *Defendants' Motion in Limine No. 7 to Exclude Evidence Re: Subsequent Remedial Measures* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/20/2008	1576 / [3101]	MOTION in Limine *Defendants' Motion in Limine No. 1 to Exclude Evidence Re: Housing and Other Evnironmental Conditions, Safety Concerns, and Programmatic Concerns* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/20/2008) (Entered: 10/20/2008)
10/20/2008	1577 / [3102]	MOTION in Limine *Defendants' Motion in Limine No. 15 Re: Definition of The Statutory Phrase "The Primary Cause"* filed by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mel-

Date Filed	Plata # / [Coleman #]	Docket Text
		lo, Paul) (Filed on 10/20/2008) (Entered: 10/20/ 2008)
	* * * *	
10/20/2008	1579 / [3104]	MOTION in Limine *No. 7 To Exclude Portions of McIntosh Opinion Testimony* filed by Marciano Plata. (Sangster, Edward) (Filed on 10/20/2008) (Entered: 10/20/2008)
	* * * *	
10/22/2008	1604 / [3125]	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to the Court's Order re 1515 Order Denying Defendants' Motion for Reconsideration - [Filing Fee: Not Paid] Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 10/22/2008) (Entered: 10/23/ 2008)
	* * * *	
10/27/2008	1611	ORDER re 1602 Stipulation regarding approval of the Inspector General's proposed

Date Filed	Plata # / [Coleman #]	Docket Text
		medical inspection program. Signed by Judge Thelton E. Henderson on 10/27/08. (tehlc3, COURT STAFF) (Filed on 10/27/2008) (Entered: 10/27/2008)
10/27/2008	1612	Transcript of Proceedings held on October 27, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Belle Ball, CSR, RMR, CRR, e-mail belle_ball@cand.uscourts.gov Telephone number (415) 373-2529. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 1/22/2009. (Ball,

Date Filed	Plata # / [Coleman #]	Docket Text
		Belle) (Filed on 10/27/2008) (Entered: 10/27/2008)
	* * * *	
10/30/2008	1622	ORDER TO SHOW CAUSE re: transition planning coordination agreement. Show Cause Response due by 11/10/2008. Signed by Judges Lawrence K. Karlton, Thelton E. Henderson, Jeffrey S. White, and Claudia Wilken on 10/30/08. (tehlc3, COURT STAFF) (Filed on 10/30/2008) (Entered: 10/30/2008)
	* * * *	
10/30/2008	1624 / [3139]	Declaration of Paul Mello *Regarding Submission of Defendants' Expert Reports* filed byMatthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Exhibit H, # 9 Exhibit I, # 10 Exhibit J, # 11 Exhibit K, # 12 Exhibit L) (O'Bannon, Danielle) (Filed

Date Filed	Plata # / [Coleman #]	Docket Text
		on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1632 / [3146]	AFFIDAVIT *Trial Affidavit of Todd Jerue* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1633 / [3148]	AFFIDAVIT *Trial Affidavit of Thomas G. Hoffman* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1634 / [3150]	AFFIDAVIT *Trial Affidavit of James Tilton* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1636 / [3152]	AFFIDAVIT *Trial Affidavit of Scott Kernan* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1640 / [3164]	AFFIDAVIT *TRIAL DECLARATION OF ROBERT GARNER* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1641 / [3165]	AFFIDAVIT *EXPERT REPORT OF ROBERT GARNER* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1642 / [3166]	AFFIDAVIT *TRIAL DECLARATION OF GARY A. GRAVES* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1643 / [3167]	AFFIDAVIT *EXPERT REPORT OF GARY GRAVES* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1644 / [3168]	AFFIDAVIT *TRIAL DECLARATION OF NANCY DANE PENA, Ph.D.* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1646 / [3169]	AFFIDAVIT *EXPERT REPORT OF NANCY PENA* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1647 / [3158]	Declaration of Dr. Ira Packer in Support of 1645 MOTION in Limine *Defendants' Opposition To Plaintiffs' Motion In Limine No. 3* filed byMatthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A)(Related document(s) 1645) (O'Bannon, Danielle) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1648 / [3174]	AFFIDAVIT *EXPERT REPORT OF PAUL McINTOSH* by County of Santa

Date Filed	Plata # / [Coleman #]	Docket Text
		Clara. (Attachments: # 1 Part 2 of McIntosh Expert Report) (Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/ 2008)
10/30/2008	1649 / [3176]	AFFIDAVIT *SUPPLEMENTAL EXPERT REPORT OF PAUL McINTOSH* by County of Santa Clara. (Fuentes, Theresa) (Filed on 10/30/ 2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1651 / [3151]	Memorandum in Opposition *to Defs MIL No. 7* filed by-Marciano Plata. (Evenson, Rebekah) (Filed on 10/30/ 2008) (Entered: 10/30/2008)
10/30/2008	1652 / [3157]	AFFIDAVIT *Trial Affidavit of Deborah Hysen* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1656 / [3173]	AFFIDAVIT *TRIAL DECLARATION OF STATE ASSEMBLYMEMBER TODD*

Date Filed	Plata # / [Coleman #]	Docket Text
		SPITZER by Todd Spitzer. (Attachments: # 1 Exhibit A-E)(Wang, Teresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1657 / [3160]	AFFIDAVIT *Trial Affidavit of Cynthia Radavsky* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/ 2008)
10/30/2008	1658 / [3177]	AFFIDAVIT *TRIAL DECLARATION OF STATE SENATOR GEORGE RUNNER* by George Runner. (Attachments: # 1 Exhibit A-H)(Wang, Teresa) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1659 / [3175]	AFFIDAVIT *Declaration of Expert Witness Richard Conklin* by Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood,

Date Filed	Plata # / [Coleman #]	Docket Text
		Contra Costa County Sheriff Warren Rupf. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1660 / [3161]	Memorandum in Opposition re 1577 MOTION in Limine *Defendants' Motion in Limine No. 15 Re: Definition of The Statutory Phrase "The Primary Cause"* filed byMarciano Plata. (Galvan, Ernest) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1661 / [3179]	AFFIDAVIT *Declaration of Expert Witness Richard Word* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny

Date Filed	Plata # / [Coleman #]	Docket Text
		Youngblood, Stanislaus County Chief Probation Officer Jerry Powers, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 10/30/ 2008) (Entered: 10/30/2008)
10/30/2008	1662 / [3170]	NOTICE by Marciano Plata *of Expert Report of Dr. James Gilligan* (Morris, Maria) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1663 / [3172]	NOTICE by Marciano Plata *of Rebuttal Expert Report of James Gilligan, M.D.* (Morris, Maria) (Filed on 10/30/ 2008) (Entered: 10/30/2008)
10/30/2008	1664 / [3178]	AFFIDAVIT *EXPERT REPORT OF DAVID M. BENNETT* by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/Coroner William Cogbill. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3

Date Filed	Plata # / [Coleman #]	Docket Text
		Exhibit C - PART 1, # 4 Exhibit C - PART 2, # 5 Exhibit C - PART 3A, # 6 Exhibit C - PART 5A, # 7 Exhibit C - PART 5B, # 8 Exhibit C - PART 5C, # 9 Exhibit C - PART 4A, # 10 Exhibit C - PART 4B, # 11 Exhibit C - PART 3C, # 12 Exhibit C - PART 2A, # 13 Exhibit C - PART 3B)(Keck, Anne) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1665 / [3202]	AFFIDAVIT *Direct Testimony Declaration of Eric Adelman* by California Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1666 / [3184]	EXHIBITS re 1664 Affidavit,, *of Expert Witness Report of David M. Bennett* filed bySonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/ Coroner William Cogbill. (Attachments: # 1 Exhibit C - PART 6B, # 2 Exhibit

Date Filed	Plata # / [Coleman #]	Docket Text
		C - PART 7A, # 3 Exhibit C - PART 7B, # 4 Exhibit C - PART 7C, # 5 Exhibit C - PART 7D, # 6 Exhibit C - PART 7E, # 7 Exhibit C - PART 8A, # 8 Exhibit C - PART 8B, # 9 Exhibit C - PART 8C, # 10 Exhibit D)(Related document(s) 1664) (Keck, Anne) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1667 / [3187]	AFFIDAVIT *Supplemental Expert Report of David M. Bennett* by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/Coroner William Cogbill. (Keck, Anne) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1669 / [3203]	AFFIDAVIT *Direct Testimony Declaration of Gary Benson* by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declara-

Date Filed	Plata # / [Coleman #]	Docket Text
		tions/ Stipulations)) (Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1670 / [3204]	AFFIDAVIT *Direct Testimony Declaration of Brenda M. Gibbons* by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declarations/Stipulations))(Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1671 / [3205]	AFFIDAVIT *Direct Testimony Declaration of Ruben Leija, Jr.* by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declarations/ Stipulations)) (Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1673 / [3192]	AFFIDAVIT *Declaration of Expert Witness John Ingrassia* by Orange County Sheriff Coroner Michael S. Carona, Placer County Sheriff Edward N. Bonner, Butte

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		County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, San Mateo County Sheriff Greg Monks, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1674 / [3207]	AFFIDAVIT *Direct Testimony Declaration of Kevin Raymond* by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declarations/Stipulations))(Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1675 / [3210]	AFFIDAVIT *Direct Testimony Declaration of Debbra*

Date Filed	Plata # / [Coleman #]	Docket Text
		Rowlett by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declarations/Stipulations))(Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1676 / [3196]	AFFIDAVIT *OF SONOMA COUNTY SHERIFF-CORONER WILLIAM COGBILL* by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/Coroner William Cogbill. (Attachments: # 1 Exhibit A - Part 1, # 2 Exhibit A - PART 2, # 3 Exhibit A - PART 3)(Keck, Anne) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1681 / [3213]	Memorandum in Opposition *PLAINTIFF INTERVENOR, CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS MEMORANDUM OF POINTS AND AUTHORITIES IN*

Date Filed	Plata # / [Coleman #]	Docket Text
		OPPOSITION TO DEFENDANTS MOTION IN LIMINE NO. 2 TO EXCLUDE (a) CCPOA WITNESSES AND (b) CCPOA TESTIMONY ABOUT HOUSING, VIOLENCE, DANGER, SECURITY filed byCalifornia Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1682 / [3190]	Declaration of THERESA J. FUENTES filed byCounty of Santa Clara. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Exhibit H)(Fuentes, Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1684 / [3188]	MEMORANDUM in Opposition *TO PLAINTIFFS' MOTION IN LIMINE NO. 7 TO EXCLUDE PORTIONS OF MCINTOSH OPINION TESTIMONY* filed byCounty of Santa Clara. (Fuentes,

Date Filed	Plata # / [Coleman #]	Docket Text
		Theresa) (Filed on 10/30/2008) (Entered: 10/30/2008)

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10/30/2008	1688 / [3197]	AFFIDAVIT *Declaration of Expert Witness Lt. Stephan M. Smith* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Yuba County Sheriff Steve Durfor, Stanislaus County Chief Probation Officer Jerry Powers, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1693 / [3220]	Memorandum in Opposition *PLAINTIFF INTERVENOR, CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANTS MOTION IN LIMINE NO. 11 TO EXCLUDE EVIDENCE RE: DESERT INSTITUTIONS* filed byCalifornia Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 10/30/ 2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1695 / [3199]	Memorandum in Opposition *"Plaintiffs' Opposition to Defendants' Motion in Limine No. 14 Regarding Evidence of DMH's Noncompliance with Court Orders"* filed by-Marciano Plata. (Whelan, Amy) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1699 / [3211]	Memorandum in Opposition *to Def's MIL # 5 to Exclude Evidence Re Sentencing Commission* filed byMarciano Plata. (Hardy, Alison) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1700 / [3194]	NOTICE by Marciano Plata *Expert Report of Barry Krisberg Ph.D.* (Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1706 / [3201]	NOTICE by Marciano Plata *Expert Report of Professor Craig Haney* (Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1707 / [3217]	NOTICE by Marciano Plata *Expert Report of Pablo Stewart, M.D.* (Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1708 / [3221]	NOTICE by Marciano Plata *Supplemental Expert Report of Pablo Stewart, M.D., and Appendix A - D (part 1)* (Attachments: # 1 Appendix D

Date Filed	Plata # / [Coleman #]	Docket Text
		(part 2) - F)(Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1709 / [3206]	AFFIDAVIT *TRIAL DECLARATION* by ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom. (Attachments: # 1 Affidavit Declaration of Rodric Pacheco)(Mitchell, William) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1710 / [3223]	Memorandum in Opposition *Plaintiffs' Opposition to Defendants' Motion in Limine No. 10 To Exclude Evidence Re: Suicide Rate in California Prisons* filed byMarciano Plata. (Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1711 / [3214]	AFFIDAVIT *TRIAL DECLARATION OF BONNIE DUMANIS* by ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom. (Mitchell, William) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1712 / [3226]	Memorandum in Opposition *Plaintiffs' Opposition to Defendants' Motion in Limine No. 11 To Exclude Any Evidence of Alleged Non-Compliance at Desert Institutions* filed byMarciano Plata. (Kahn, Jane) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1713 / [3216]	AFFIDAVIT *TRIAL DECLARATION OF LISA RODRIGUEZ* by ROD PA-

Date Filed	Plata # / [Coleman #]	Docket Text
		CHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom. (Attachments: # 1 Affidavit Trial Declaration of Lisa Rodriguez)(Mitchell, William) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1714 / [3231]	Declaration of Donald Specter *Re Submission of Plaintiffs' Expert Reports of Austin, Krisberg, Lehman, Reingold, Scott, Shansky, and Wooford* filed byMarciano Plata. (Attachments: # 1 Exhibit Exhibit A, # 2 Exhibit Exhibit B, # 3 Exhibit Exhibit C, # 4 Exhibit Exhibit D, # 5 Exhibit Exhibit E, # 6 Exhibit Exhibit F, # 7 Exhibit Exhibit G, # 8 Exhibit Exhibit H, # 9 Exhibit Exhibit I, # 10 Appendix Appen-

Date Filed	Plata # / [Coleman #]	Docket Text
		dix to Exhibit I, # 11 Exhibit Exhibit J, # 12 Exhibit Exhibit K, # 13 Exhibit Exhibit L, # 14 Exhibit Exhibit M, # 15 Exhibit Exhibit N) (Hardy, Alison) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1715 / [3228]	AFFIDAVIT *Trial Affidavit of Robin Dezember* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1716 / [3229]	AFFIDAVIT *Trial Affidavit of Kathy Jett* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1717 / [3230]	AFFIDAVIT *Trial Affidavit of Matthew Cate* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1722 / [3233]	AFFIDAVIT *Declaration of Witness Rick Dostal* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Attachments: # 1 Exhibit Exhibit to Declaration of Witness Rick Dostal) (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1723 / [3235]	AFFIDAVIT *Declaration of Expert Witness Chief Alexander Yim* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendo-

Date Filed	Plata # / [Coleman #]	Docket Text
		cino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1724 / [3234]	Pretrial Conference Statement by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger *Joint Pre-Trial Statement*. (Attachments: # 1 Exhibit A - B, # 2 Exhibit C, # 3 Exhibit D, # 4 Exhibit E, # 5 Exhibit F - H)(Mello, Paul) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1725 / [3235]	AFFIDAVIT *Declaration of Expert Witness Chief Alexander Yim* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendocino County Sheriff Tom

Date Filed	Plata # / [Coleman #]	Docket Text
		Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1726 / [3236]	AFFIDAVIT *Declaration of Expert Witness Sheriff Martin Ryan* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendocino County Sheriff Tom Allman, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1727 / [3237]	AFFIDAVIT *Declaration of Expert Witness Adam Christianson* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis

Date Filed	Plata # / [Coleman #]	Docket Text
		Downum, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, San Mateo County Sheriff Greg Monks, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
10/30/2008	1728 / [3238]	AFFIDAVIT *Declaration of Expert Witness Mike James* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Barlow, Kim-

Date Filed	Plata # / [Coleman #]	Docket Text
		berly) (Filed on 10/30/ 2008) (Entered: 10/30/2008)
10/30/2008	1729 / [3239]	Memorandum in Opposition *to Defendants' MIL No. 1* filed byMarciano Plata. (Norman, Sara) (Filed on 10/30/2008) (Entered: 10/30/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/30/2008	1733 / [3243]	AFFIDAVIT *Declaration of Expert Witness Don Meyer* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, San Mateo County Sheriff Greg Monks, Contra Costa County Sheriff Warren Rupf, River-

Date Filed	Plata # / [Coleman #]	Docket Text
		side County Sheriff Bob G. Doyle. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/ 2008)
	* * * *	
10/30/2008	1735 / [3245]	AFFIDAVIT *Declaration of Expert Witness Karen Dalton* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, San Mateo County Sheriff Greg Monks, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle. (Barlow, Kimberly) (Filed on 10/30/2008) (Entered: 10/30/2008)
	* * * *	
10/31/2008	1741 /	AFFIDAVIT re 1726 Affidavit, *Exhibit to Declaration of*

Date Filed	Plata # / [Coleman #]	Docket Text
	[3251]	*Martin Ryan* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 10/31/2008) (Entered: 10/31/2008)
10/31/2008	1742 / [3252]	AFFIDAVIT re 1723 Affidavit, 1725 Affidavit, *Declaration of Chief Alexander Yim* by Placer County Sheriff Edward N. Bonner, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, Stanislus County Sheriff Adam Chris-

Date Filed	Plata # / [Coleman #]	Docket Text
		tianson, Mendocino County Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Shasta County Sheriff Tom Bosenko, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 10/31/2008) (Entered: 10/31/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/31/2008	1744	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to re 1610 Second Order for further proceedings re: Receiver's Motion for Contempt & all other orders that gave rise to that order. Filed by Defendants Arnold Schwarzenegger, et al. - [Filing Fee: $455.00, Receipt

Date Filed	Plata # / [Coleman #]	Docket Text
		Number 34611025016]. (tn, COURT STAFF) (Filed on 10/31/ 2008) (Entered: 10/31/2008)
10/31/2008	1745 / [3254]	San Diego County Sheriff William B. Kolender, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Yuba County Sheriff Steve Durfor, Stanislaus County Chief Probation Officer Jerry Powers, San Mateo County Sheriff Greg Munks.. *Declaration of Expert Witness Karen Dalton..* (Barlow, Kimberly) (Filed on 10/31/2008) (Entered: 10/31/2008)
10/31/2008	1746 / [3255]	San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff,

Date Filed	Plata # / [Coleman #]	Docket Text
		Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Stanislus County Sheriff Adam Christianson, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks.. Amendment to re 1733 *Declaration of Expert Witness Don Meyer..* (Barlow, Kimberly) (Filed on 10/31/ 2008) (Entered: 10/31/2008)
10/31/2008	1747 / [3256]	*Declaration of Ivy M. Tsai re Submission of Law Enforcement Intervenors' Expert Reports* by San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles Coun-

Date Filed	Plata # / [Coleman #]	Docket Text
		ty Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Solano County Sheriff Gary R. Stanton. (Barlow, Kimberly) (Filed on 10/31/2008) (Entered: 10/31/2008)

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11/03/2008	1752	RESPONSE to *Defendants' Response to Order Re: Stipulation Regarding Approval of the Inspector General's Proposed Medical Inspection Program* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 11/3/2008) (Entered: 11/03/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
11/03/2008	1753 / [3258]	TRIAL BRIEF by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/Coroner William Cogbill. (Keck, Anne) (Filed on 11/3/2008) (Entered: 11/03/2008)
11/03/2008	1754	ORDER GRANTING Receiver's Application for Order Waiving State Statutes, Regulations and Procedures. Signed by Judge Thelton E. Henderson on 11/03/08. (rbe, COURT STAFF) (Filed on 11/3/2008) (Entered: 11/03/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/03/2008	1757 / [3260]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1478 Defendants' motion for dismissal or, alternatively, summary judgment. (tehlc3, COURT STAFF) (Filed on 11/3/2008) (Entered: 11/03/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
11/03/2008	1758 / [3261]	TRIAL BRIEF *OF COUNTY INTERVENORS* by County of Santa Clara. (Fuentes, Theresa) (Filed on 11/3/2008) (Entered: 11/03/2008)
11/03/2008	1759 / [3262]	TRIAL BRIEF *Defendants' Joint Trial Brief* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 11/3/2008) (Entered: 11/03/2008)
11/03/2008	1760 / [3263]	TRIAL BRIEF *Legislator Intervenors' Trial Brief* by Anthony Adams, Greg Aghazarian, Joel Anderson, John J. Benoit, Tom Berryhill, Sam Blakeslee, Paul Cook,, Chuck DeVore, Michael D. Duvall, Bill Emmerson, Jean Fuller, Ted Gaines, Martin Garrick, Shirley Horton, Guy S. Houston, Bob Huff, Kevin Jeffries, Rick Keene, Doug La Malfa, Bill Maze, Alan Nakanishi, Roger Niello,, George A. Plescia, Sharon Runner, Jim Silva, Cameron Smyth, Todd Spitzer, Audra Strickland, Van Tran,

Date Filed	Plata # / [Coleman #]	Docket Text
		Mimi Walters, Samuel Aanestad, Dick Ackerman, Roy Ashburn, Dave Cogdill, Dave Cox, Jeff Denham, Bob Dutton, Dennis Hollingsworth, Abel Maldonado, George Runner, Bob Margett, Mark Wyland. (Wang, Teresa) (Filed on 11/3/2008) (Entered: 11/03/2008)

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11/04/2008	1761 / [3267]	TRIAL BRIEF by California Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 11/4/2008) (Entered: 11/04/2008)

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11/04/2008	1763 / [3266]	TRIAL BRIEF *by Law Enforcement and District Attorneys Intervenors* by Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County

Date Filed	Plata # / [Coleman #]	Docket Text
		Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 11/4/2008) (Entered: 11/04/2008)
	* * * *	
11/05/2008	1766 / [3268]	*Plaintiffs' Trial Brief* by Marciano Plata. (Evenson, Rebekah) (Filed on 11/5/2008) (Entered: 11/05/2008)
	* * * *	
11/10/2008	1781 / [3271]	Minute Entry: Three-Judge Court Pretrial Conference held. (Court Reporter: Lydia Zinn) (rbe, COURT STAFF)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Date Filed: 11/10/2008) (Entered: 11/10/2008)
11/10/2008	1782 / [3272]	ORDER bifurcating trial in three-judge court proceedings. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 11/10/08. (tehlc3, COURT STAFF) (Filed on 11/10/2008) (Entered: 11/10/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/12/2008	1786	Transcript of Proceedings held on 11/10/2008, before Judge Thelton E. Henderson, Lawrence K. Karlton, Stephen Reinhardt. Court Reporter/Transcriber Lydia Zinn, Telephone number (415) 531-6587. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained

Date Filed	Plata # / [Coleman #]	Docket Text
		through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 2/9/2009. (Zinn, Lydia) (Filed on 11/12/2008) (Entered: 11/12/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/13/2008	1796	Transcript of Proceedings held on November 7, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 busi-

Date Filed	Plata # / [Coleman #]	Docket Text
		ness days from date of this filing. Release of Transcript Restriction set for 2/9/2009. (Columbini, Joan) (Filed on 11/13/2008) (Entered: 11/13/2008)
11/13/2008	1797 / [3285]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 1784 Plaintiffs' motion for reconsideration. (tehlc3, COURT STAFF) (Filed on 11/13/2008) (Entered: 11/13/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/17/2008	1815 / [3301]	Pretrial Conference Statement by Arnold Schwarzenegger *Joint Pretrial Conference Statement*. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D)(Mello, Paul) (Filed on 11/17/2008) (Entered: 11/17/2008)
11/17/2008	1816 / [3302]	OBJECTIONS to re 1794 Response (Non Motion) *to Order Re: Deposition Excerpts at Trial* by Sonoma County District Attorney Stephan Passalacqua, So-

Date Filed	Plata # / [Coleman #]	Docket Text
		noma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/ Coroner William Cogbill. (Keck, Anne) (Filed on 11/17/2008) (Entered: 11/17/2008)

* * * *

11/17/2008	1821 / [3309]	MOTION for Reconsideration *Defendants' Request for Reconsideration of Oral Ruling Prohibiting Evidence Re Constitutional Compliance at Trial* filed by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 11/17/2008) (Entered: 11/17/2008)

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11/17/2008	1823 / [3310]	ERRATA *TO DEFENDANTS' TRIAL AFFIDAVITS* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 11/17/2008) (Entered: 11/17/2008)

* * * *

Date Filed	Plata # / [Coleman #]	Docket Text
11/18/2008	1825 / [3313]	STIPULATION AND ORDER re: Modification of Order Sealing Deposition of Expert Witness Haney. Signed by Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt on 11/18/08. (rbe, COURT STAFF) (Filed on 11/18/2008) Modified on 11/18/2008 (rbe, COURT STAFF). (Entered: 11/18/2008)
11/18/2008	1826 / [3317]	Minute Entry: Bench Trial held on 11/18/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 11/19/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 11/18/2008) (Entered: 11/18/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/19/2008	1829	Transcript of Proceedings held on November 18, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Katherine Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 2/17/2009. (Columbini, Joan) (Filed on 11/19/2008) (Entered: 11/19/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/19/2008	1831 / [3321]	Minute Entry: Bench Trial held on 11/19/2008 before Judges Thelton E. Hender-

Date Filed	Plata # / [Coleman #]	Docket Text
		son, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 11/20/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 11/19/2008) (Entered: 11/19/2008)
11/20/2008	1832	Transcript of Proceedings held on November 19, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Katherine Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if

Date Filed	Plata # / [Coleman #]	Docket Text
		required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 2/17/2009. (Columbini, Joan) (Filed on 11/20/2008) (Entered: 11/20/ 2008)

* * * *

11/20/2008	1834 / [3319]	OBJECTIONS to *Plaintiffs' Objections and Defendants' Responses to Trial Affidavit of Cynthia A. Radavsky* by Marciano Plata. (Ells, Lisa) (Filed on 11/20/2008) (Entered: 11/20/2008)

* * * *

11/20/2008	1837	United States Court of Appeals for the Ninth Circuit ORDER as to re 1744 Notice of Appeal Filed by Defendants Arnold Schwarzenegger, et al.. (tn, COURT STAFF) (Filed on 11/20/ 2008) (Entered: 11/20/2008)

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11/20/2008	1839 [3322]	Minute Entry: Bench Trial held on 11/20/2008 before Judges Thelton E. Hender-

Date Filed	Plata # / [Coleman #]	Docket Text
		son, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 11/21/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (rbe, COURT STAFF) (Date Filed: 11/20/2008) (Additional attachment(s) added on 11/20/2008: # 1 Trial Log) (rbe, COURT STAFF). (Entered: 11/20/2008)
11/21/2008	1840	Transcript of Proceedings held on November 20, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Kathy Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through

Date Filed	Plata # / [Coleman #]	Docket Text
		PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 2/17/2009. (Columbini, Joan) (Filed on 11/21/2008) (Entered: 11/21/2008)
11/21/2008	1841	STATUS REPORT *Receiver and State Personnel Board's Further Joint Status Report re Physician Clinical Competency Determination Policies and Procedures* by J. Clark Kelso. (Dodd, Martin) (Filed on 11/21/2008) (Entered: 11/21/2008)
	* * * *	
11/21/2008	1844 / [3323]	Minute Entry: Bench Trial held on 11/21/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/2/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporter: Joan Columbini) (Attachments: # 1 Trial Log)

Date Filed	Plata # / [Coleman #]	Docket Text
		(rbe, COURT STAFF) (Date Filed: 11/21/2008) (Entered: 11/21/2008)
11/23/2008	1845	Transcript of Proceedings held on November 21, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 2/18/2009. (Columbini, Joan) (Filed on 11/23/2008) (Entered: 11/23/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
11/26/2008	1856 / [3329]	OBJECTIONS to re 1715 Affidavit *Joint Statement Regarding Plts' Objections to Robin Dezember Trial Affidavit and Defs' Responses Thereto* by Marciano Plata. (Whelan, Amy) (Filed on 11/26/2008) (Entered: 11/26/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/01/2008	1874	United States Court of Appeals for the Ninth Circuit MANDATE re Appeal No. 08-16682. (tn, COURT STAFF) (Filed on 12/1/2008) (Entered: 12/02/2008)
12/02/2008	1869 / [3341]	OBJECTIONS to *Defendants Trial Objections to Expert Report of Barry Krisberg and Plaintiffs Responses to Defendants Objections* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Lewis, Kyle) (Filed on 12/2/2008) (Entered: 12/02/2008)
12/02/2008	1870 / [3340]	NOTICE by ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael

Date Filed	Plata # / [Coleman #]	Docket Text
		Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom *Notice of Lodging Deposition Trnascript with Corrections of Bonnie Dumanis, DA* (Mitchell, William) (Filed on 12/2/2008) (Entered: 12/02/2008)
12/02/2008	1871 / [3342]	NOTICE by ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom *Notice of Lodging Deposition Transcript Part I of Rod Pacheco* (Mitchell, William) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		12/2/2008) (Entered: 12/02/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/02/2008	1876 / [3345]	Minute Entry: Bench Trial held on 12/2/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/3/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/2/2008) (Entered: 12/02/2008)
12/03/2008	1877	Transcript of Proceedings held on December 2, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Katherine Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through

Date Filed	Plata # / [Coleman #]	Docket Text
		the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/2/2009. (Columbini, Joan) (Filed on 12/3/2008) (Entered: 12/03/ 2008)
12/03/2008	1878 / [3347]	Minute Entry: Bench Trial held on 12/3/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/4/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/3/2008) (Entered: 12/03/ 2008)
12/04/2008	1879	Transcript of Proceedings held on December 3, 2008,

Date Filed	Plata # / [Coleman #]	Docket Text
		before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Katherine Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/2/2009. (Columbini, Joan) (Filed on 12/4/2008) (Entered: 12/04/ 2008)
12/04/2008	1880 / [3349]	ERRATA re 1759 Trial Brief *Defendants' Errata to Trial Brief* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 12/4/2008) (Entered: 12/04/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
12/04/2008	1881 / [3363]	Minute Entry: Bench Trial held on 12/4/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/5/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Kathy Wyatt) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/4/2008) (Entered: 12/04/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/05/2008	1883	Transcript of Proceedings held on December 4, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Katherine Wyatt, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for

Date Filed	Plata # / [Coleman #]	Docket Text
		the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/2/2009. (Columbini, Joan) (Filed on 12/5/2008) (Entered: 12/05/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/05/2008	1896 / [3364]	Minute Entry: Bench Trial held on 12/5/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/9/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporter: Joan Columbini) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/5/2008) (Entered: 12/05/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/05/2008	1901	United States Court of Appeals for the Ninth Circuit

Date Filed	Plata # / [Coleman #]	Docket Text
		MANDATE as to re 1335 Notice of Appeal Filed by Arnold Schwarzenegger & Michael C. Genest. (tn, COURT STAFF) (Filed on 12/5/2008) (Entered: 12/05/2008)

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12/08/2008	1904	Transcript of Proceedings held on December 5, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript

Date Filed	Plata # / [Coleman #]	Docket Text
		Restriction set for 3/5/2009. (Columbini, Joan) (Filed on 12/8/2008) (Entered: 12/08/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/09/2008	1917 / [3383]	Minute Entry: Bench Trial held on 12/9/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/10/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporter: Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/9/2008) (Entered: 12/09/2008)
12/09/2008	1918 / [3379]	OBJECTIONS to *"Plaintiffs' Objections to Trial Affidavit of Todd Spitzer and Defendant Legislator Intervenors' Responses Thereto"* by Marciano Plata. (Whelan, Amy) (Filed on 12/9/2008) (Entered: 12/09/2008)
12/09/2008	1919 /	OBJECTIONS to *pliffs' obj to Dyer expert report* by Mar-

Date Filed	Plata # / [Coleman #]	Docket Text
	[3380]	ciano Plata. (Fama, Steven) (Filed on 12/9/2008) (Entered: 12/09/2008)
12/10/2008	1920	Transcript of Proceedings held on December 9, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini, Debra L. Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/9/2009. (Columbini, Joan) (Filed on 12/10/2008) (Entered: 12/10/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/10/2008	1922 / [3382]	STIPULATION *Regarding Testimony of Beverly Beasley Johnson* by Marciano Plata. (Sangster, Edward) (Filed on 12/10/2008) (Entered: 12/10/2008)
12/10/2008	1923 / [3387]	ERRATA *TO EXPERT REPORT OF DAVID M. BENNET, DATED* by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Sheriff/Coroner William Cogbill. (Attachments: # 1 Exhibit C - PART 1, # 2 Exhibit C - PART 2, # 3 Exhibit C - PART 3, # 4 Exhibit C - PART 4, # 5 Exhibit C - PART 5, # 6 Exhibit C - PART 6, # 7 Exhibit C - PART 7)(Keck, Anne) (Filed on 12/10/2008) (Entered: 12/10/2008)
12/10/2008	1924 / [3388]	ERRATA re 1923 Errata, *TO EXPERT REPORT OF DAVID M. BENNET, EXHIBIT C - PART 8* by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, So-

Date Filed	Plata # / [Coleman #]	Docket Text
		noma County Sheriff/ Coroner William Cogbill. (Attachments: # 1 Exhibit C - PART 9, # 2 Exhibit C - PART 10, # 3 Exhibit C - PART 11, # 4 Exhibit C - PART 12, # 5 Exhibit C - PART 13, # 6 Exhibit C - PART 14, # 7 Exhibit C - PART 15)(Keck, Anne) (Filed on 12/10/2008) (Entered: 12/10/2008)
12/10/2008	1925 / [3386]	OBJECTIONS to *Declaration of Rodric Pacheco* by Marciano Plata. (Sangster, Edward) (Filed on 12/10/2008) (Entered: 12/10/2008)
12/10/2008	1926 / [3390]	Minute Entry: Bench Trial held on 12/10/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/11/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date

Date Filed	Plata # / [Coleman #]	Docket Text
		Filed: 12/10/2008) (Entered: 12/10/2008)
		* * * *
12/10/2008	1928 / [3389]	OBJECTIONS to "*Plaintiffs Objections to the Declaration of David S. Boesch*" by Marciano Plata. (Whelan, Amy) (Filed on 12/10/2008) (Entered: 12/10/2008)
12/11/2008	1929	Transcript of Proceedings held on December 10, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Debra Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later

Date Filed	Plata # / [Coleman #]	Docket Text
		than 5 business days from date of this filing. Release of Transcript Restriction set for 3/9/2009. (Columbini, Joan) (Filed on 12/11/2008) (Entered: 12/11/ 2008)
12/11/2008	1930 / [3396]	Minute Entry: Bench Trial held on 12/11/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/12/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/11/2008) Modified on 12/11/2008 (rbe, COURT STAFF). (Entered: 12/11/ 2008)
12/11/2008	1931 / [3391]	STIPULATION *Regarding Testimony of Charlene A. Silva* by Marciano Plata. (Ells, Lisa) (Filed on 12/11/ 2008) (Entered: 12/11/2008)
12/11/2008	1932 / [3392]	AFFIDAVIT *of Ivy M. Tsai re Corrected Expert Report of*

Date Filed	Plata # / [Coleman #]	Docket Text
		Jerry Dyer by Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Kern County Sheriff Donny Youngblood, Stanislaus County Chief Probation Officer Jerry Powers, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/11/2008) (Entered: 12/11/2008)
12/11/2008	1933 / [3393]	OBJECTIONS to *Expert Report of Dyer and Defendant-Intervenors' Response Thereto* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Los Angeles County Sheriff Lee Baca, Stanislus County Sheriff Adam Christianson, Tehama County Sheriff Clay Parker, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Stanislaus County Chief Probation Officer Jerry Powers, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		12/11/2008) (Entered: 12/11/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/12/2008	1935	Transcript of Proceedings held on December 11, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Debra L. Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/9/2009. (Columbini, Joan) (Filed on 12/12/2008) (Entered: 12/12/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
12/12/2008	1937 / [3395]	AMENDED DOCUMENT by Placer County Sheriff Edward N. Bonner, Los Angeles County Sheriff Lee Baca, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, San Mateo County Sheriff Greg Monks, Contra Costa County Sheriff Warren Rupf, Riverside County Sheriff Bob G. Doyle, San Mateo County Sheriff Greg Munks. Amendment to 1932 Affidavit, *of Ivy M. Tsai Regarding Corrected Expert Report of Jerry Dyer*. (Barlow, Kimberly) (Filed on 12/12/2008) (Entered: 12/12/2008)
12/12/2008	1938 / [3399]	Minute Entry: Bench Trial held on 12/12/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/18/2008 at 09:15 AM in the Ceremonial Courtroom,

Date Filed	Plata # / [Coleman #]	Docket Text
		19th Floor, San Francisco. (Court Reporters Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/12/2008) (Entered: 12/12/2008)
12/15/2008	1939	Transcript of Proceedings held on December 12, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Debra L. Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/12/2009. (Columbini, Joan)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 12/15/2008) (Entered: 12/15/ 2008)
12/15/2008	1940 / [3397]	STIPULATION *Regarding the Trial Testimony of David S. Boesch* by Marciano Plata. (Whelan, Amy) (Filed on 12/15/2008) (Entered: 12/15/ 2008)
12/15/2008	1941 / [3398]	STIPULATION *Regarding Testimony of Commander John Ingrassia* by Marciano Plata. (Sangster, Edward) (Filed on 12/15/2008) (Entered: 12/15/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/16/2008	1944 / [3404]	STIPULATION *Stipulation re Testimony of Arthur Reingold, M.D.* by Marciano Plata. (Attachments: # 1 Exhibit Exhibit A to Stipulation re Testimony of Arthur Reingold, M.D.)(Fama, Steven) (Filed on 12/16/2008) (Entered: 12/16/2008)
12/17/2008	1945 / [3405]	STIPULATION *Regarding Testimony of Chief Loren Buddress* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/2008) (Entered: 12/17/ 2008)

Date Filed	Plata # / [Coleman #]	Docket Text
12/17/2008	1946 / [3406]	OBJECTIONS to *Trial Declaration of Martin Ryan* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1947 / [3411]	AFFIDAVIT *of William B. Kolender re San Diego County Jail Statistics* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf. (Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1948 / [3412]	AFFIDAVIT *of Sheriff Tom Bosenko Re Shasta County Jail Statistics* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff,

Date Filed	Plata # / [Coleman #]	Docket Text
		Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1949 / [3413]	AFFIDAVIT *of Sheriff Stanley Sniff Re Riverside County Jail Statistics* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff

Date Filed	Plata # / [Coleman #]	Docket Text
		Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko. (Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1950 / [3407]	AFFIDAVIT *of Sheriff Bill Brown Re Santa Barbara County Jail Statistics* by ----------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, San Mateo Coun-

Date Filed	Plata # / [Coleman #]	Docket Text
		ty Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1951 / [3408]	AFFIDAVIT *of Tom Allman Re Mendocino County Jail Statistics* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
12/17/2008	1952 / [3409]	AFFIDAVIT *of Sheriff Donny Youngblood re Kern County Jail Statistics* by ----------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly)

Date Filed	Plata # / [Coleman #]	Docket Text
		(Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1953 / [3410]	AFFIDAVIT *of Margaret Mims Re Fresno County Jail Statistics* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks.

Date Filed	Plata # / [Coleman #]	Docket Text
		(Barlow, Kimberly) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1954 / [3414]	STIPULATION *Regarding Testimony of Karen Dalton* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1955 / [3415]	STIPULATION *Regarding Testimony of William Cogbill* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/2008) (Entered: 12/17/2008)
12/17/2008	1956 / [3416]	ERRATA *to Declaration of Expert Witness Martin Ryan* by San Diego County Sheriff William B. Kolender, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Teha-

Date Filed	Plata # / [Coleman #]	Docket Text
		ma County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/17/ 2008) (Entered: 12/17/2008)

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12/17/2008	1959 / [3419]	OBJECTIONS to *Trial Declaration of Rick Dostal* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/ 2008) (Entered: 12/17/2008)
12/17/2008	1960 / [3420]	OBJECTIONS to *Trial Declaration of Michael James* by Marciano Plata. (Sangster, Edward) (Filed on 12/17/ 2008) (Entered: 12/17/2008)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
12/18/2008	1964 / [3424]	OBJECTIONS to *Trial Declartion of George Runner and the Legislator Intervenors' Responses Thereto* by Marciano Plata. (Sangster, Edward) (Filed on 12/18/2008) (Entered: 12/18/2008)
12/18/2008	1965 / [3429]	Minute Entry: Bench Trial held on 12/18/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 12/19/2008 at 09:15 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/18/2008) (Entered: 12/18/2008)
12/18/2008	1966 / [3425]	STIPULATION *Regarding Testimony of Duane Bay* by Marciano Plata. (Sangster, Edward) (Filed on 12/18/2008) (Entered: 12/18/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
12/18/2008	1967 / [3426]	STIPULATION *Regarding Testimony of MIchael James* by Marciano Plata. (Sangster, Edward) (Filed on 12/18/2008) (Entered: 12/18/2008)
12/18/2008	1968 / [3427]	AFFIDAVIT *Supplemental Declaration of Witness Rick Dostal* by ---------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Contra Costa County Sheriff Warren Rupf, Shasta County

Date Filed	Plata # / [Coleman #]	Docket Text
		Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 12/18/ 2008) (Entered: 12/18/2008)
12/19/2008	1969	Transcript of Proceedings held on December 18, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Debra L. Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of

Date Filed	Plata # / [Coleman #]	Docket Text
		Transcript Restriction set for 3/16/2009. (Columbini, Joan) (Filed on 12/19/2008) (Entered: 12/19/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/19/2008	1971 / [3430]	Minute Entry: Bench Trial held on 12/19/2008 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 2/4/2009 at 09:00 AM in the Ceremonial Courtroom, 19th Floor, San Francisco. (Court Reporters: Joan Columbini/Debra Pas) (Attachments: # 1 Trial Log) (rbe, COURT STAFF) (Date Filed: 12/19/ 2008) (Entered: 12/19/2008)
12/22/2008	1972	Transcript of Proceedings held on December 19, 2008, before Judge Thelton E. Henderson. Court Reporter/Transcriber Joan Marie Columbini/Debra L. Pas, Telephone number 415-255-6842. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks

Date Filed	Plata # / [Coleman #]	Docket Text
		Office public terminal or may be purchased through the Court Reporter/ Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 3/19/2009. (Columbini, Joan) (Filed on 12/22/2008) (Entered: 12/22/ 2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/23/2008	1976 / [3433]	Statement *of Plaintiffs' Designations of Discovery Responses, Exhibits A, B* by Marciano Plata. (Attachments: # 1 Exhibit C-E, # 2 Exhibit F-G, # 3 Exhibit H-I, # 4 Exhibit J Part 1, # 5 Exhibit J Part 2, # 6 Exhibit J Part 3, # 7 Exhibit J Part 4, # 8 Exhibit J Part 5)(Morris, Maria) (Filed on 12/23/2008) (Entered: 12/23/2008)

Date Filed	Plata # / [Coleman #]	Docket Text
12/23/2008	1977 / [3434]	Statement re 1976 Statement, *of Plaintiffs' Designations of Discovery Responses (continued), Exhibit K,* by Marciano Plata. (Attachments: # 1 Exhibit L-M, # 2 Exhibit N, # 3 Exhibit O Part 1, # 4 Exhibit O Part 2, # 5 Exhibit P, # 6 Exhibit Q, # 7 Exhibit R, # 8 Exhibit S-T, # 9 Exhibit U)(Morris, Maria) (Filed on 12/23/2008) (Entered: 12/23/2008)
12/23/2008	1978 / [3435]	Statement re 1977 Statement, 1976 Statement, *of Plaintiffs' Designations of Discovery Responses (continued), Exhibit V,* by Marciano Plata. (Attachments: # 1 Exhibit W, # 2 Exhibit X, # 3 Exhibit Y, # 4 Exhibit Z, # 5 Exhibit AA, # 6 Exhibit BB, # 7 Exhibit CC, # 8 Exhibit DD-EE, # 9 Exhibit FF) (Morris, Maria) (Filed on 12/23/2008) (Entered: 12/23/2008)
12/23/2008	1979 / [3436]	Statement re 1977 Statement, 1978 Statement, 1976 Statement, *of Plaintiffs' Designations of Discovery Res-*

Date Filed	Plata # / [Coleman #]	Docket Text
		ponses (continued), Exhibit GG by Marciano Plata. (Attachments: # 1 Exhibit HH, # 2 Exhibit II Part 1, # 3 Exhibit II Part 2, # 4 Exhibit JJ, # 5 Exhibit KK, # 6 Exhibit LL)(Morris, Maria) (Filed on 12/23/2008) (Entered: 12/23/ 2008)
12/23/2008	1980 / [3437]	Statement re 1977 Statement, 1978 Statement, 1979 Statement, 1976 Statement, *of Plaintiffs' Designations of Discovery Responses (continued), Exhibit MM,* by Marciano Plata. (Attachments: # 1 Exhibit NN Part 1, # 2 Exhibit NN Part 2, # 3 Exhibit OO, # 4 Exhibit PP, # 5 Exhibit QQ Part 1, # 6 Exhibit QQ Part 2)(Morris, Maria) (Filed on 12/23/2008) (Entered: 12/23/2008)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/08/2009	1990 / [3443-3444]	TRANSCRIPT DESIGNATION *for Deposition Transcripts* by Marciano Plata. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2A, # 3 Exhibit 2B, # 4 Exhibit 2C, # 5 Ex-

Date Filed	Plata # / [Coleman #]	Docket Text
		hibit 3, # 6 Exhibit 4, # 7 Exhibit 5)(Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/ 2009)
01/08/2009	1991 / [3444-3445]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 6A, # 2 Exhibit 6B, # 3 Exhibit 6C, # 4 Exhibit 7, # 5 Exhibit 8, # 6 Exhibit 9, # 7 Exhibit 10, # 8 Exhibit 11, # 9 Exhibit 12, # 10 Exhibit 13)(Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/ 2009)
01/08/2009	1992 / [3445-3447]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 14, # 2 Exhibit 15, # 3 Exhibit 16, # 4 Exhibit 17A, # 5 Exhibit 17B, # 6 Exhibit 17C, # 7 Exhibit 17D, # 8 Exhibit 18, # 9 Exhibit 19A, # 10 Exhibit 19B)(Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/ 2009)

Date Filed	Plata # / [Coleman #]	Docket Text
01/08/2009	1993 / [3447, 3449]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 20A, # 2 Exhibit 20B, # 3 Exhibit 20C, # 4 Exhibit 21, # 5 Exhibit 22, # 6 Exhibit 23, # 7 Exhibit 24A, # 8 Exhibit 24B, # 9 Exhibit 24C, # 10 Exhibit 24D, # 11 Exhibit 25) (Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/08/2009	1995 / [3450-3451]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 26A, # 2 Exhibit 26B, # 3 Exhibit 27, # 4 Exhibit 28A, # 5 Exhibit 28B, # 6 Exhibit 28C, # 7 Exhibit 29, # 8 Exhibit 30, # 9 Exhibit 31, # 10 Exhibit 32A, # 11 Exhibit 32B, # 12 Exhibit 33)(Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/2009)

Date Filed	Plata # / [Coleman #]	Docket Text
01/08/2009	1996 / [3451-3453]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 34A, # 2 Exhibit 34B, # 3 Exhibit 34C, # 4 Exhibit 34D, # 5 Exhibit 34E, # 6 Exhibit 34F, # 7 Exhibit 34G, # 8 Exhibit H, # 9 Exhibit 34I, # 10 Exhibit 34J, # 11 Exhibit 34K, # 12 Exhibit 34L, # 13 Exhibit 34M, # 14 Exhibit 35) (Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08 /2009)
01/08/2009	1997 / [3453-3455]	TRANSCRIPT DESIGNATION *of Deposition Transcripts, Continued* by Marciano Plata. (Attachments: # 1 Exhibit 36A, # 2 Exhibit 36B, # 3 Exhibit 37, # 4 Exhibit 38A, # 5 Exhibit 38B, # 6 Exhibit 38C, # 7 Exhibit 38D, # 8 Exhibit 38E, # 9 Exhibit 39, # 10 Exhibit 40, # 11 Exhibit 41, # 12 Exhibit 42, # 13 Exhibit 43A, # 14 Exhibit 43B, # 15 Exhibit 44, # 16 Exhibit 45)(Morris, Maria) (Filed on 1/8/2009) (Entered: 01/08/2009)

Date Filed	Plata # / [Coleman #]	Docket Text

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01/16/2009	2009 / [3460]	RESPONSE to re 1985 Order *Re: Governor's Budget Proposal* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 1/16/2009) (Entered: 01/16/2009)

* * * *

01/20/2009	2011	NOTICE by J. Clark Kelso *Notice of Filing of Receiver's Tenth Tri-Annual Report* (Attachments: # 1 Tenth Tri-Annual Report)(Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2012	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Table of Appendices and Appendices 1 to 5* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2013	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 6 to 18* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)

Date Filed	Plata # / [Coleman #]	Docket Text
01/20/2009	2014	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 19 to 23* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2015	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 30 to 34* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2016	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 35 to 43* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2017	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 24 to 25* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2018	NOTICE by J. Clark Kelso re 2011 Notice (Other) *Appendices 26 to 29* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2019	NOTICE by J. Clark Kelso re 2011 Notice (Other) *(refiled) Appendices 6 to 18 (doc*

Date Filed	Plata # / [Coleman #]	Docket Text
		2013 damaged) (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2020	NOTICE by J. Clark Kelso re 2011 Notice (Other) *(re-filed) Appendices 6 to 13 (doc 2018 damaged)* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2021	NOTICE by J. Clark Kelso re 2011 Notice (Other) *(re-filed) Appendices 14 to 15 (doc 2019 damaged)* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2022	NOTICE by J. Clark Kelso re 2011 Notice (Other) *(re-filed) Appendices 16 to 18 (doc 2019 damaged)* (Dodd, Martin) (Filed on 1/20/2009) (Entered: 01/20/2009)
01/20/2009	2023 / [3472]	OBJECTIONS to *Law Enforcement Intervenor Trial Exhibits* by Marciano Plata. (Sangster, Edward) (Filed on 1/20/2009) (Entered: 01/20/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/23/2009	2028 / [3479]	Proposed Findings of Fact by County of Santa Clara, County of Santa Barbara, County of San Mateo *AND CONCLUSIONS OF LAW*. (Fuentes, Theresa) (Filed on 1/23/2009) (Entered: 01/23/2009)
01/23/2009	2029 / [3481]	Proposed Findings of Fact by Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma County Sheriff/ Coroner William Cogbill. (Attachments: # 1 Exhibit A)(Keck, Anne) (Filed on 1/23/2009) (Entered: 01/23/2009)
01/23/2009	2030 / [3482]	Proposed Findings of Fact by George Runner *LEGISLATOR INTERVENORS' [PROPOSED] FINDINGS OF FACT AND CONCLUSIONS OF LAW*. (Wang, Teresa) (Filed on 1/23/2009) (Entered: 01/23/2009)
01/23/2009	2031 / [3480]	Proposed Order *Defendants' Proposed Findings of Fact and Conclusions of Law Re*

Date Filed	Plata # / [Coleman #]	Docket Text
		Ruling on Plaintiffs' Request for a Prisoner Release Order by James E. Tilton, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 1/23/2009) (Entered: 01/23/2009)
01/23/2009	2032 / [3483]	Proposed Findings of Fact by California Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 1/23/2009) (Entered: 01/23/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/23/2009	2035 / [3485]	Proposed Findings of Fact by ROD PACHECO, Bonnie M. Dumanis, Tony Rackauckas, Jan Scully, Christie Stanley, Michael Ramos, Robert Kochly, David W. Paulson, Gregg Cohen, Todd Riebe, Bradford Fenocchio, John R. Poyner, Michael Ramsey, Gerald T. Shea, Edward R. Jagels, GREGORY TOTTEN, Vern Pierson, Clifford Newell, Ronald L. Calhoun, Donald Segerstrom. (Mitchell, William) (Filed on 1/23/2009) (Entered: 01/23/2009)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
01/28/2009	2037 / [3488]	NOTICE by Marciano Plata *"Errata to Plaintiffs' Proposed Findings of Fact and Conclusions of Law"* (Whelan, Amy) (Filed on 1/28/2009) (Entered: 01/28/2009)
01/28/2009	2038 / [3489]	Proposed Order *"Plaintiffs' CORRECTED Proposed Findings of Fact and Conclusions of Law"* by Marciano Plata. (Bien, Michael) (Filed on 1/28/2009) (Entered: 01/28/2009)
01/28/2009	2039	MOTION *Defendants' Motion: 1) To Replace the Receiver with a Special Master and, During the Transition, to Establish a Process to Ensure the Receiver's Compliance with State and Federal Law; and 2) To Terminate the Receiver's Construction Plan* filed by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. Motion Hearing set for 3/9/2009 10:00 AM in Courtroom 12, 19th Floor, San Francisco. (East, Rochelle) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		1/28/2009) (Entered: 01/28/2009)
		* * * *
01/30/2009	2049 / [3491]	Proposed Findings of Fact by ----------- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Tehama County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers,

Date Filed	Plata # / [Coleman #]	Docket Text
		Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 1/30/ 2009) (Entered: 01/30/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/30/2009	2053	ORDER GRANTING Receiver's Supplemental Application No. 8. Signed by Judge Thelton E. Henderson on 01/29/09. (rbe, COURT STAFF) (Filed on 1/30/2009) (Entered: 01/30/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/03/2009	2059	NOTICE by J. Clark Kelso *Updated Analyses Regarding Projected Need for Long-Term Care Facilities for CDCR Inmate-Patients* (Attachments: # 1 Exhibits 1 to 4)(Dodd, Martin) (Filed on 2/3/2009) (Entered: 02/03/ 2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/03/2009	2061 / [3507]	Minute Entry: Bench Trial held on 2/3/2009 before Judges Thelton E. Hender-

Date Filed	Plata # / [Coleman #]	Docket Text
		son, Lawrence K. Karlton and Stephen Reinhardt. Further Bench Trial set for 2/4/2009 10:00 AM in Courtroom 1, 3rd Floor, Ninth Circuit Court of Appeals, San Francisco. (Court Reporter: Debra Pas) (rbe, COURT STAFF) (Date Filed: 2/3/2009) (Entered: 02/03/2009)
02/04/2009	2062 / [3508]	Minute Entry: Bench Trial completed on 2/4/2009 before Judges Thelton E. Henderson, Lawrence K. Karlton and Stephen Reinhardt. (Court Reporter: Debra Pas) (rbe, COURT STAFF) (Date Filed: 2/4/2009) (Entered: 02/04/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/04/2009	2064 / [3509]	ORDER requiring further briefing. Supplemental briefing on specified funding questions due on or before 02/18/09. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 02/04/09. (tehlc3, COURT

Date Filed	Plata # / [Coleman #]	Docket Text
		STAFF) (Filed on 2/4/2009) (Entered: 02/04/2009)
02/06/2009	2065	NOTICE by J. Clark Kelso *Receiver's Report on Options for Long-Term Care Bed Construction* (Dodd, Martin) (Filed on 2/6/2009) (Entered: 02/06/2009)
02/09/2009	2066 / [3514]	TENTATIVE RULING in three-judge court proceedings. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 02/09/09. (tehlc3, COURT STAFF) (Filed on 2/9/2009) (Entered: 02/09/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/12/2009	2072	Transcript of Proceedings held at the Ninth Circuit Court of Appeals on 2/3/2009, before Judge Thelton E. Henderson. Court Reporter/Transcriber Debra L. Pas, Telephone number (415) 431-1477. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public ter-

Date Filed	Plata # / [Coleman #]	Docket Text
		minal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 5/11/2009. (Pas, Debra) (Filed on 2/12/ 2009) (Entered: 02/12/2009)
02/12/2009	2073	Transcript of Proceedings held at the Ninth Circuit Court of Appeals on 2/4/2009, before Judge Thelton E. Henderson. Court Reporter/Transcriber Debra L. Pas, Telephone number (415) 431-1477. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After

Date Filed	Plata # / [Coleman #]	Docket Text
		that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. Release of Transcript Restriction set for 5/11/2009. (Pas, Debra) (Filed on 2/12/ 2009) (Entered: 02/12/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/18/2009	2076 / [3519]	RESPONSE to *Order Requiring Further Briefing* by Marciano Plata. (Evenson, Rebekah) (Filed on 2/18/2009) (Entered: 02/18/2009)
02/18/2009	2077 / [3520]	RESPONSE to *RESPONSE OF THE LEGISLATOR INTERVENORS AND DISTRICT ATTORNEY INTERVENORS TO THE THREE-JUDGE COURT'S FEBRUARY 4, 2008 ORDER REQUIRING FURTHER BRIEFING* by ROD PACHECO, George Runner. (Wang, Teresa) (Filed on 2/18/2009) (Entered: 02/18/2009)

Date Filed	Plata # / [Coleman #]	Docket Text
02/18/2009	2078 / [3521]	RESPONSE to re 2064 Order, *The Courts February 4, 2009 Order Requiring Further Briefing* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 2/18/2009) (Entered: 02/18/2009)
02/18/2009	2079 / [3522]	RESPONSE to *Order Requiring Further Briefing* by California Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 2/18/2009) (Entered: 02/18/2009)
02/18/2009	2080 / [3523]	TRIAL BRIEF *POST* by County of Santa Clara, County of San Mateo. (Fuentes, Theresa) (Filed on 2/18/2009) (Entered: 02/18/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
02/18/2009	2082 / [3524]	RESPONSE to re 2064 Order, *Response to Order Requiring Further Briefing,* by County of Sonoma, Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Proba-

Date Filed	Plata # / [Coleman #]	Docket Text
		tion Office Robert Ochs, Sonoma County Sheriff/ Coroner William Cogbill. (Keck, Anne) (Filed on 2/18/2009) (Entered: 02/18/2009)
02/18/2009	2083 / [3525]	TRIAL BRIEF *POST* by Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Mendocino County Sheriff Tom Allman, Lassen County Sheriff Steve Warren, Kern County Sheriff Donny Youngblood, Contra Costa County Sheriff Warren Rupf. (Barlow, Kimberly) (Filed on 2/18/2009) (Entered: 02/18/2009)
02/19/2009	2084 / [3527]	RESPONSE to *Appointment of Settlement Referees Per Tentative Ruling* by County of Sonoma, Sonoma County District Attorney Stephan Passalacqua, Sonoma County Chief Probation Office Robert Ochs, Sonoma Coun-

Date Filed	Plata # / [Coleman #]	Docket Text
		ty Sheriff/Coroner William Cogbill. (Keck, Anne) (Filed on 2/19/2009) (Entered: 02/19/2009)
02/19/2009	2085 / [3528]	RESPONSE to *RESPONSE OF LEGISLATOR INTERVENORS re SETTLEMENT REFEREES, PURSUANT TO THE THREE-JUDGE COURT'S FEBRUARY 9, 2009 TENTATIVE RULING* by George Runner. (Wang, Teresa) (Filed on 2/19/2009) (Entered: 02/19/2009)
02/19/2009	2086 / [3529]	RESPONSE to re 2066 Order *Tentative Ruling* by ------ ----- San Diego County Sheriff William B. Kolender, Placer County Sheriff Edward N. Bonner, Butte County Sheriff- Coroner Perry L. Reniff, Calaveras County Sheriff Dennis Downum, Los Angeles County Sheriff Lee Baca, Santa Clara County Sheriff Laurie Smith, San Benito County Sheriff Curtis Hill, Stanislus County Sheriff Adam Christianson, Mendocino County Sheriff Tom Allman, Teha-

Date Filed	Plata # / [Coleman #]	Docket Text
		ma County Sheriff Clay Parker, Lassen County Sheriff Steve Warren, Yolo County Sheriff Ed Prieto, Santa Barbara County Sheriff Bill Brown, Kern County Sheriff Donny Youngblood, Yuba County Sheriff Steve Durfor, Contra Costa County Sheriff Warren Rupf, Shasta County Sheriff Tom Bosenko, Stanislaus County Chief Probation Officer Jerry Powers, Ventura County Sheriff Bob Brooks, Solano County Sheriff Gary R. Stanton, San Mateo County Sheriff Greg Munks. (Barlow, Kimberly) (Filed on 2/19/2009) (Entered: 02/19/ 2009)
02/19/2009	2087 / [3530]	RESPONSE to *COURT'S REQUEST FOR PARTIES TO ADVISE RE COURT APPOINTED SETTLEMENT REFEREE* by County of Santa Clara, County of Santa Barbara, County of San Mateo. (Fuentes, Theresa) (Filed on 2/19/2009) (Entered: 02/19/2009)

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Date Filed	~Plata # / [Coleman #]	Docket Text
02/20/2009	2093	United States Court of Appeals for the Ninth Circuit ORDER as to re 1604 Notice of Appeal: Granting Appellants' Motion for Voluntary Dismissal under the Federal Rule of Appellate Procedure 42(b). (tn, COURT STAFF) (Filed on 2/20/2009) (Entered: 02/23/2009)

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Date Filed	~Plata # / [Coleman #]	Docket Text
02/23/2009	2095	Memorandum in Opposition *to Defs' Motion to Replace Receiver with Spec. Master and Terminate Receiver's Construction Plan* filed by Marciano Plata. (Hardy, Alison) (Filed on 2/23/2009) (Entered: 02/23/2009)
02/23/2009	2096	Memorandum in Opposition *to Defendants' Motion to Terminate the Receivership and Receiver's Construction Plans* filed byJ. Clark Kelso. (Attachments: # 1 Affidavit Kirkland Declaration, # 2 Exhibit Kirkland Declaration Exhbit A, # 3 Exhibit Kirkland Declaration Exhibit B, # 4 Exhibit Kirkland

Date Filed	Plata # / [Coleman #]	Docket Text
		Declaration Exhibit C, # 5 Affidavit Cambra Deckaration, # 6 Affidavit Goldman Declaration, # 7 Affidavit Kimura-Yip Declaration, # 8 Affidavit Plunkett Declaration, # 9 Affidavit Hill Declaration, # 10 Exhibit Hill Declaration Exhibit A, # 11 Exhibit Hill Declaration Exhibit B, # 12 Exhibit Hill Declaration Exhibit C, # 13 Exhibit Hill Declaration Exhibit D, # 14 Exhibit Hill Declaration Exhibit E, # 15 Exhibit Hill Declaration Exhbit F, # 16 Exhibit Hill Declaration Exhibit G, # 17 Exhibit Hill Declaration Exhibit H, # 18 Affidavit Hagar Declaration, # 19 Exhibit Hagar Declaration Exhibit A, # 20 Exhibit Hagar Declaratio Exhibit B) (Brosnahan, James) (Filed on 2/23/2009) (Entered: 02/23/2009)
	* * * *	
03/09/2009	2125	Reply to Opposition *DEFENDANTS REPLY TO THE RECEIVERS AND*

Date Filed	Plata # / [Coleman #]	Docket Text
		PLAINTIFFS OPPOSITION TO DEFENDANTS TERMINATION MOTION filed byArnold Schwarzenegger. (Attachments: # 1 Signature Page (Declarations/ Stipulations) Proof of Service) (Kwong, William) (Filed on 3/9/2009) (Entered: 03/09/2009)
	* * * *	
03/17/2009	2128	Transcript of Proceedings held on March 16, 2009, before Judge Thelton E. Henderson. Court Reporter/ Transcriber Christine A. Triska, Telephone number (650) 743-8425. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerks Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction.After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no

Date Filed	Plata # / [Coleman #]	Docket Text
		later than 5 business days from date of this filing. Release of Transcript Restriction set for 6/12/2009. (cat, COURT STAFF) (Filed on 3/17/2009) (Entered: 03/17/2009)
		* * * *
04/23/2009	2144	NOTICE OF APPEAL to the United States Court of Appeals for the Ninth Circuit as to the Court's re 2132 Order Denying Defendants' Motion to Replace Receiver with Special Master to Terminate the Receiver's Construction Plan Filed by Defendants Arnold Schwarzenegger, et al. - [Filing Fee: $455.00, Receipt Number 34611031374]. (tn, COURT STAFF) (Filed on 4/23/2009) (Entered: 04/24/2009)
		* * * *
06/01/2009	2167	NOTICE by J. Clark Kelso *Notice of Filing of Receiver's Eleventh Tri-Annual Report* (Attachments: # 1 Eleventh Tri-Annual Report, # 2 Table of Appendices)(Dodd, Mar-

Date Filed	Plata # / [Coleman #]	Docket Text
		tin) (Filed on 6/1/2009) (Entered: 06/01/2009)
06/01/2009	2168	Appendix re 2167 Notice (Other) *Appendices 1 to 10* filed byJ. Clark Kelso. (Related document(s) 2167) (Dodd, Martin) (Filed on 6/1/2009) (Entered: 06/01/2009)
06/01/2009	2169	Appendix re 2167 Notice (Other) *Appendices 11 to 12* filed byJ. Clark Kelso. (Related document(s) 2167) (Dodd, Martin) (Filed on 6/1/2009) (Entered: 06/01/2009)
06/01/2009	2170	Appendix re 2167 Notice (Other) *Appendices 13 to 15* filed byJ. Clark Kelso. (Related document(s) 2167) (Dodd, Martin) (Filed on 6/1/2009) (Entered: 06/01/2009)
06/01/2009	2171	Appendix re 2167 Notice (Other) *Appendices 16 to 18* filed byJ. Clark Kelso. (Related document(s) 2167) (Dodd, Martin) (Filed on 6/1/2009) (Entered: 06/01/2009)

Date Filed	Plata # / [Coleman #]	Docket Text
06/01/2009	2172	Appendix re 2167 Notice (Other) *Appendices 19 to 24* filed byJ. Clark Kelso. (Related document(s) 2167) (Dodd, Martin) (Filed on 6/1/2009) (Entered: 06/01/2009)
		* * * * *
07/29/2009	2190 / [3637]	Request for Judicial Notice filed byMarciano Plata. (Evenson, Rebekah) (Filed on 7/29/2009) (Entered: 07/29/ 2009)
		* * * *
08/04/2009	2196 / [3640]	OBJECTIONS to re 2190 Request for Judicial Notice by Arnold Schwarzenegger. (Attachments: # 1 Attachment to Defendants' Objections to Plaintiffs' Request for Judicial Notice)(Mello, Paul) (Filed on 8/4/2009) (Entered: 08/04/2009)
08/04/2009	2197 / [3641]	OPINION AND ORDER by three-judge court re: prison overcrowding. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and

Date Filed	Plata # / [Coleman #]	Docket Text
		Thelton E. Henderson on 08/04/09. (tehlc3, COURT STAFF) (Filed on 8/4/2009) (Entered: 08/04/2009)
08/04/2009	2198 / [3642]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson ruling on evidentiary matters related to 2197 Opinion and Order. (tehlc3, COURT STAFF) (Filed on 8/4/2009) (Entered: 08/04/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/01/2009	2216 / [3655]	MOTION to Stay *Three-Judge Court's August 4, 2009 Opinion and Order Pending Appeal; Memorandum of Points and Authorities* filed by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 9/1/2009) (Entered: 09/01/ 2009)
09/02/2009	2217 / [3657]	MOTION compel defs to consult with pltfs and to produce data *relevant to population reduction plan; declaration of Rebekah Evenson* filed by Marciano

Date Filed	Plata # / [Coleman #]	Docket Text
		Plata. (Evenson, Rebekah) (Filed on 9/2/2009) (Entered: 09/02/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/03/2009	2218 / [3662]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson denying 2216 Motion to Stay August 4, 2009 Order. (tehlc3, COURT STAFF) (Filed on 9/3/2009) (Entered: 09/03/2009)
09/03/2009	2220 / [3663]	*NOTICE OF APPEAL to the Supreme Court of the United States from the Court's re 2197 Opinion & Order*, [Filing Fee: $455.00, Receipt Number 34611036298]. Filed by Defendant Legislator Intervenors, District Attorney Intervenors, Sheriff, Police Chief, Probation Chief & Corrections Intervenors (Collectively, the "Statutory Intervenors), George Runner, et al.. (Attachments: #(1) Exhibit Receipt of payment for Notice of Appeal in Eastern District of CA). (Stegeman, Chad) (Filed on

Date Filed	Plata # / [Coleman #]	Docket Text
		9/3/2009) (Entered: 09/03/ 2009)
09/03/2009	2224 / [3659]	NOTICE OF APPEAL to the Supreme Court of the United States as to the Court's re 2197 Opinion & Order Filed by Defendants Arnold Schwarzenegger, John Craig, Michael C. Genest, Matthew Cate & Stephen W. Mayberg - [Filing Fee: $455.00, Receipt Number 34611036211]. (tn, COURT STAFF) (Filed on 9/3/2009) (Entered: 09/04/ 2009)
		* * * *
09/08/2009	2226 / [3668]	Memorandum in Opposition re 2217 MOTION compel defs to consult with pltfs and to produce data *relevant to population reduction plan; declaration of Rebekah Evenson DEFENDANTS OPPOSITION TO PLAINTIFFS MOTION TO COMPEL DEFENDANTS TO CONSULT WITH PLAINTIFFS AND PRODUCE DATA RELEVANT TO POPULATION REDUC-*

Date Filed	Plata # / [Coleman #]	Docket Text
		TION PLAN filed byMatthew Cate, Michael C. Genest. (Antonen, Charles) (Filed on 9/8/2009) (Entered: 09/08/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/11/2009	2231 / [3670]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 2217 Plaintiffs' motion to compel re: population reduction plan. (tehlc3, COURT STAFF) (Filed on 9/11/2009) (Entered: 09/11/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/18/2009	2237 / [3678]	RESPONSE to *Defendants' Population Reduction Plan* by Matthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(O'Bannon, Danielle) (Filed on 9/18/2009) (Entered: 09/18/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
09/30/2009	2248	NOTICE by J. Clark Kelso *Notice of Filing of Receiver's*

Date Filed	Plata # / [Coleman #]	Docket Text
		Twelfth Tri-Annual Report (Attachments: # 1 Receiver's Twelfth Tri-Annual Report, # 2 Table of Appendices)(Dodd, Martin) (Filed on 9/30/2009) (Entered: 09/30/2009)
09/30/2009	2249	Appendix re 2248 Notice (Other) *Appendices 1 through 8* filed byJ. Clark Kelso. (Related document(s) 2248) (Dodd, Martin) (Filed on 9/30/2009) (Entered: 09/30/2009)
09/30/2009	2250	Appendix re 2248 Notice (Other) *Appendices 9 through 17* filed byJ. Clark Kelso. (Related document(s) 2248) (Dodd, Martin) (Filed on 9/30/2009) (Entered: 09/30/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/02/2009	2253 / [3696]	ORDER by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson granting 2238 Motion to Intervene by Assembly Republicans. (tehlc3, COURT STAFF) (Filed on 10/2/2009) (Entered: 10/02/2009)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
10/08/2009	2256 / [3699]	RESPONSE to *Def's Population Reduction Plan and App for OSC re Contempt* by Marciano Plata. (Evenson, Rebekah) (Filed on 10/8/2009) (Entered: 10/08/2009)
10/08/2009	2257 / [3700]	Proposed Order *to Show Cause re Contempt* by Marciano Plata. (Evenson, Rebekah) (Filed on 10/8/2009) (Entered: 10/08/2009)
10/08/2009	2258 / [3701]	AFFIDAVIT *of Rebekah Evenson in support of Plf's Response to Def Population Reduction Plan and App for OSC re Contempt* by Marciano Plata. (Evenson, Rebekah) (Filed on 10/8/2009) (Entered: 10/08/2009)
10/08/2009	2259 / [3702]	OBJECTIONS to *The Republican Assembly and Senate Intervenors' Objections to the Defendants' Population Reduction Plan* by George Runner. (Stegeman, Chad) (Filed on 10/8/2009) (Entered: 10/08/2009)

Date Filed	Plata # / [Coleman #]	Docket Text
10/08/2009	2260 / [3703]	RESPONSE to *Defendants' Population Reduction Plan* by California Correctional Peace Officers Association. (Leonard, Natalie) (Filed on 10/8/2009) (Entered: 10/08/2009)
10/08/2009	2261 / [3704]	AFFIDAVIT *of Steve Weiss in Support of Intervenor CCPOA's Objections to Defendants' Population Reduction Plan* by California Correctional Peace Officers Association. (Attachments: # 1 Signature Page (Declarations/Stipulations) of Steve Weiss)(Leonard, Natalie) (Filed on 10/8/2009) (Entered: 10/08/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
10/21/2009	2269 / [3711]	ORDER rejecting defendants' proposed population plan and directing the submission of a plan that complies with the August 4, 2009 Opinion and Order. Defendants' submission shall be filed within 21 days. Signed by Judges Stephen Reinhardt, Lawrence K.

Date Filed	Plata # / [Coleman #]	Docket Text
		Karlton, and Thelton E. Henderson on 10/21/09. (tehlc3, COURT STAFF) (Filed on 10/21/ 2009) (Entered: 10/21/2009)
	* * * *	
11/09/2009	2271	United States Court of Appeals for the Ninth Circuit OPINION re 1390 Notice of Appeal. (tn, COURT STAFF) (Filed on 11/9/2009) (Entered: 11/09/2009)
	* * * *	
11/12/2009	2274 / [3726]	RESPONSE to *Defendants' Response to Three-Judge Court's October 21, 2009 Order* by Matthew Cate, Arnold Schwarzenegger. (Attachments: # 1 Exhibit State Defendants' November 12, 2009 Response to the Three-Judge Court's October 21, 2009 Order to Reduce Prison Population to 137.5% of Design Capacity, # 2 Exhibit Declaration of Jay Atkinson in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order, # 3 Exhibit Declara-

Date Filed	Plata # / [Coleman #]	Docket Text
		tion of David Lewis in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order, # 4 Exhibit Declaration of Scott Kernan in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order, # 5 Exhibit Declaration of Sharon Aungst in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order, # 6 Exhibit Declaration of Robert Ambroselli in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order, # 7 Exhibit Declaration of Elizabeth Siggins in Support of Defendants' Response to Three-Judge Court's October 21, 2009 Order)(Mello, Paul) (Filed on 11/12/2009) (Entered: 11/12/2009)
11/18/2009	2275 / [3730]	ORDER inviting responses from plaintiffs and intervenors to 2274 Defendants' November 12, 2009 proposed prison population reduction measures. Plaintiffs' and in-

Date Filed	Plata # / [Coleman #]	Docket Text
		tervenors' responses, if any, due by 12/07/09. Defendants' response due by 12/18/09. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on 11/18/09. (tehlc3, COURT STAFF) (Filed on 11/18/2009) (Entered: 11/18/2009)
	* * * *	
12/07/2009	2278 / [3740]	RESPONSE to re 2274 Response (Non Motion), Response (Non Motion), Response (Non Motion), Response (Non Motion), Response (Non Motion) *County Intervenors and Sonoma County Intervenors' Joint Response to Defendants' November 12, 2009 Proposed Prison Population Reduction Measures* by County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Sonoma, Sonoma County Chief Probation Office Robert Ochs, Sonoma County District Attorney Stephan Passalacqua, Sonoma County Sheriff/ Co-

Date Filed	Plata # / [Coleman #]	Docket Text
		roner William Cogbill. (Keck, Anne) (Filed on 12/7/2009) (Entered: 12/07/2009)
12/07/2009	2279 / [3741]	RESPONSE to re 2274 Response (Non Motion), Response (Non Motion), Response (Non Motion), Response (Non Motion), Response (Non Motion) *The Republican Assembly And Senate Intervenors' Objections To The Defendants' November 12, 2009 Submission* by George Runner. (Kaufhold, Steven) (Filed on 12/7/2009) (Entered: 12/07/2009)
12/07/2009	2280 / [3742]	RESPONSE to *Defendants' Nov. 12, 2009 Population Reduction Plan* by Marciano Plata. (Evenson, Rebekah) (Filed on 12/7/2009) (Entered: 12/07/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/18/2009	2284 / [3753]	Reply Memorandum *DEFENDANTS' REPLY TO RESPONSES TO DEFENDANTS' NOVEMBER 12, 2009 REVISED POPULA-*

Date Filed	Plata # / [Coleman #]	Docket Text
		TION REDUCTION PLAN filed byMatthew Cate, Michael C. Genest, Arnold Schwarzenegger. (Mello, Paul) (Filed on 12/18/2009) (Entered: 12/18/2009)

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Date Filed	Plata # / [Coleman #]	Docket Text
12/18/2009	2286 / [3755]	OBJECTIONS to re 2280 Response (Non Motion) *re Defendants' November 12, 2009 Proposed Plan CORRECTION TO DOCKET NO. 2285* by County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Sonoma, Sonoma County Chief Probation Office Robert Ochs, Sonoma County District Attorney Stephan Passalacqua, Sonoma County Sheriff/ Coroner William Cogbill. (Keck, Anne) (Filed on 12/18/2009) (Entered: 12/18/2009)
01/12/2010	2287 / [3767]	ORDER to reduce prison population. Signed by Judges Stephen Reinhardt, Lawrence K. Karlton, and Thelton E. Henderson on

Date Filed	Plata # / [Coleman #]	Docket Text
		01/12/10. (tehlc3, COURT STAFF) (Filed on 1/12/2010) (Entered: 01/12/2010)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/15/2010	2289	NOTICE by J. Clark Kelso *of Filing the Receiver's 13th Tri-Annual Report* (Attachments: # 1 Receiver's 13th Tri-Annual Report, # 2 Table of Contents to Appendices, # 3 Appendices 1 to 7)(Dodd, Martin) (Filed on 1/15/2010) (Entered: 01/15/2010)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/19/2010	2291 / [3772]	Defendant Arnold Schwarzenegger's *NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES as to the Court's re 2287 Order to Reduce Prison Population*. (Mello, Paul) (Filed on 1/19/2010) (Entered: 01/19/2010)

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Date Filed	Plata # / [Coleman #]	Docket Text
01/20/2010	2294 / [3775]	NOTICE OF APPEAL to the United States SUPREME COURT as to the Court's re

Date Filed	Plata # / [Coleman #]	Docket Text
		2287 Order to Reduce Prison Population. Filed by Republican ssembly & Senate Intervenors, District Attorney Intervenors, Sheriff, Police Chief, Probation Chief & Corrections Intervenors. (tn, COURT STAFF) (Filed on 1/20/2010) (Entered: 01/21/2010)

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Date Filed	Plata # / [Coleman #]	Docket Text
05/27/2010	2316	NOTICE by J. Clark Kelso *of Filing of Receiver's Fourteenth Tri-Annual Report* (Attachments: #(1) 14th Tri-Annual Report, #(2) Table of Appendices, #(3) Appendices 1 to 6, #(4) Appendices 7 to 12)(Dodd, Martin) (Filed on 5/27/2010) (Entered: 05/27/2010)

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Date Filed	Plata # / [Coleman #]	Docket Text
07/27/2010	2325	NOTICE by J. Clark Kelso *of Withdrawal of Motion for Contempt Re Docket No. 1379* (Plunkett, Stuart) (Filed on 7/27/2010) (Entered: 07/27/2010)

Date Filed	Plata # / [Coleman #]	Docket Text

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Date Filed	Plata # / [Coleman #]	Docket Text
10/04/2010	2337	Notice of Filing of Receiver's Amended Fifteenth Tri-Annual Report filed by Receiver J. Clark Kelson. (Attachments: #(1) Amended Page - Notice, #(2) Receiver's Amended 15th Report)(Dodd, Martin) (Filed on 10/4/2010) (Entered: 10/04/2010)

* * * *

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. Civ S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

On March 3, 2006, this court ordered defendants to file, by April 17, 2006, a plan for the provision of acute and intermediate inpatient beds for all seriously mentally ill male and female inmates in the California Department of Corrections and Rehabilitation (CDCR) clinically determined to be in need of those levels of inpatient care, and for the provision of mental health crisis beds for all seriously mentally ill male and female inmates in CDCR within 24 hours of a clinical determination that they require that level of care. (Order filed March 3, 2005, at ¶¶ 3, 5.) The court also set a hearing for April 26, 2006 on the adequacy of the plan.

On April 17, 2006, defendants filed a Statewide Mental Health Bed Plan. On April 21, 2006, plaintiffs filed a series of objections to the plan. The matter came on for hearing on April 26 and 27, 2006, before the undersigned. Michael Bien, Esq., appeared as counsel for plaintiffs. Lisa Tillman, Deputy Attorney General, appeared as counsel for defendants.

[2] At the start of the hearing, the court provided the parties with a series of questions to be addressed. Thereafter, the court heard sworn testimony from a number of state officials in response to the questions. The court has carefully considered that testimony, the plan and its supporting documents, and plaintiffs' objections thereto and their supporting evidence.

At issue is the access to necessary and constitutionally adequate levels of care for the most seriously mentally ill inmates in the CDCR, including the availability of sufficient numbers of acute inpatient beds, intermediate inpatient beds, and mental health crisis beds. In their objections, plaintiffs note that the bed plan submitted to the court in April 2006 was based on population projections that were outdated by the time the plan was filed. There is no dispute that the population figures on which the April 2006 plan is based are already out of date.[1] Thus, while the long range plan appears sound in principle, it may require adjustments based on the new population data now available to defendants. The long range plan will be approved subject to modification based on the new population data.

The special master reports, the record reflects, and defendants admit, that the plan presented to the court in no way adequately responds to the severe shortage of intermediate care facility beds and mental health crisis beds that currently exists in the CDCR. It is undisputed that the shortage is leaving critically mentally ill inmates languishing in horrific conditions without access to immediately necessary mental health care. In his testimony, Dr. Peter Farber-Szekrenyi, who was appointed to the position of CDCR's Director of Health Care Services on December 1, 2005, repeatedly referred to the shortage as a "crisis," a description entirely supported by the record before this court. Dr. Farber-Szekrenyi testified that at present there is a shortage of 75 mental health crisis beds and 125 intermediate inpatient beds. In the latter [3] category, the most serious shortfall is in beds for inmates who have a Level IV security classification.

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[1] In addition, defendants do not dispute that the methodology used to project future need for mental health care services, developed in 2002, also needs to be updated. Douglas McKeever, Project Director for the Mental Health Care Services Division of CDCR, testified that defendants have entered into a contract to update the methodology.

Over the course of the hearing, and in consultation with the special master, several options emerged that are immediately available to help address both aspects of the crisis. One requires a short discussion; all will be made an order of this court.

At present, there is a unit at California Men's Colony (CMC) presently being used as an outpatient housing unit. Until approximately one year ago, this unit was a locked observation unit (LOU) and provided 36 beds to inmates in need of a mental health crisis bed level of care. Following a state court decision requiring the CDCR to bring its medical treatment centers into compliance with state law licensing requirements,[2] the locked observation unit was closed and reopened as an outpatient housing unit. The closure of the locked observation unit, and defendants' failure to replace the beds lost thereby, accounts for a significant portion of the current shortfall in mental health crisis beds.

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[2] *Budd, et al. v. Cambra, et al.*, Case No. 319578, Order Granting Plaintiffs' Motion for Summary Judgment and Permanent Injunction, filed August 14, 2002 in the San Francisco County Superior Court.

State licensing requirements serve an important function, and the judgments of state courts are ordinarily, based on important concerns of comity and federalism, deferred to by federal courts. However, "the Supreme Court has stated that otherwise valid state laws or court orders cannot stand in the way of a federal court's remedial scheme if the action is essential to enforce the scheme." *Stone v. City and County of San Francisco*, 968 F.2d 850, 862 (9th Cir. 1992) (quoting, *inter alia*, *North Carolina State Bd. of Educ. v. Swann*, 402 U.S. 43, 45, 91 S.Ct. 1284, 1286, 28 L.Ed.2d 586 (1971).) It is essential to provide immediately mental health crisis beds to critically ill inmates in the CDCR. Reopening of the locked observation unit will remedy expeditiously a substantial amount of the shortage of such beds. Under present circumstances, state licensing requirements must temporarily give way to measures necessary to remedy the [4] Eighth Amendment violations that remain unresolved in this action. Defendants will therefore be directed to reopen forthwith the locked observation unit at CMC and to use it to provide 36 mental health crisis beds to class members until further order of this court.

In accordance with the foregoing, and good cause appearing, IT IS HEREBY ORDERED that:

1. The defendants' long term plan for provision of acute and intermediate inpatient care and mental health crisis beds is approved, subject to modification based on current population projections. Within sixty days from the date of this order defendants shall file an amended long term plan that is based on current population projections and incorporates an updated

version of the methodology first adopted in the 2002 Tucker-Alan bed needs projections.

2. The defendants' long term plan for enhanced outpatient beds describes a shortfall of over 1000 such beds in the year 2011 and therefore is not approved.

3. Defendants shall include with the amended long term plan a list of those projects that can be accelerated as well as a list of any statutory, licensing, or staffing barriers to such acceleration and/or to timely opening of the projects described in the amended long term plan.

4. Within forty-five days from the date of this order defendants shall file a plan for interim provision of intermediate inpatient beds and mental health crisis beds. Defendants shall include with said interim plan, as appropriate, a list of any statutory, licensing, or staffing barriers to implementation of any aspect of said plan.

5. Plaintiffs are granted a period of ten days in which to file and serve a response to the interim plan required by paragraph 3 of this order.

6. Defendants shall maintain thirty-six (36) intermediate inpatient beds at the California Medical Facility (CMF) P-2 unit until further order of court. In connection therewith, defendants are reminded of their obligations under the heat plan developed pursuant to prior [5] orders of this court, and defendants are directed to take every mechanical step presently feasible to maintain appropriate temperatures within said unit.

7. Not later than May 30, 2006, defendants shall open thirty-six (36) intermediate inpatient beds at

Salinas Valley State Prison (SVSP) that were slated to receive inmates from CMF. Said beds shall be used for Level IV inmates.

8. Defendants shall create an additional thirty-six (36) intermediate inpatient beds at SVSP on the same time schedule and with the same waivers used to create the thirty-six (36) beds referred to in paragraph 7 of this order. Said beds shall also be used for Level IV inmates.

9. Defendants shall forthwith review the list of 123 inmates presently awaiting placement in the interediate inpatient bed program at SVSP and shall identify all inmates on said list appropriate for placement in the DMH program at Atascadero State Hospital or Coalinga State Hospital. The provisions of the current memorandum of understanding between the CDCR and the California Department of Mental Health (DMH) notwithstanding, said review and identification shall be made by appropriate officials of the CDCR. Thereafter, appropriate officials of both CDCR and DMH shall take all steps necessary to facilitate promptly said placement decisions. Any dispute between CDCR and DMH over the appropriateness of a placement shall be promptly submitted to the special master for decision.

10. Twenty-five (25) intermediate inpatient beds shall be made immediately available at Coalinga State Hospital for appropriate CDCR inmates. Within thirty days thereafter, an additional 25 intermediate inpatient beds shall be made available at Coalinga State Hospital for appropriate CDCR inmates.

11. Within six months from the date of this order, defendants shall file a report on the feasibility and

cost of creating thirty (30) intermediate inpatient beds at Coalinga State Hospital beds for Level IV high-custody CDCR inmates. Said report shall be prepared by the CDCR in collaboration with DMH and the California Department of General Services.

[6] 12. Defendants shall activate the mental health crisis beds in the correctional treatment centers at Kern Valley State Prison and California State Prison-Sacramento not later than July 1, 2006, or inform the court in writing by that date why said centers are not fully operational.

13. Defendants shall forthwith reopen the locked observation unit at the California Men's Colony (CMC) as a thirty-six (36) bed mental health crisis bed unit on a temporary emergency basis. Said mental health crisis beds shall remain in use until further order of this court.

14. Until further order of this court, defendants shall not close any intermediate inpatient bed or mental health crisis bed on the basis of state licensing requirements without approval of the special master.

DATED: May 1, 2006.

/s/ Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

On November 3, 2006, plaintiffs' motion for a temporary restraining order to enjoin the scheduled out-of-state transfer on November 3, 2006 of 80 inmates confined to California Department of Rehabilitation and Corrections (CDCR) came on regularly for hearing. Michael Bien, Esq. and Donald Specter, Esq., appeared as counsel for plaintiffs. Lisa Tillman, Deputy Attorney General, appeared as counsel for defendants.

At the conclusion of the hearing, the court ruled from the bench and directed counsel for defendants to prepare a proposed written order. Both parties have tendered proposed orders and each has been considered by the court. At the further hearing set in this order, the parties may raise for discussion and further consideration any issue raised in either of the proposed orders that is not specifically resolved by this order.

[2] Upon review of the submitted pleadings and arguments offered by counsel, IT IS HEREBY ORDERED that:

1. Plaintiffs' motion for a temporary restraining order to enjoin the scheduled transfer of 80 CDCR inmates on November 3, 2006 is denied.

2. Defendants are to place an appropriately-credentialed mental health clinician employed by CDCR on the scheduled flight to travel with the 80 inmates on November 3, 2006 to the out-of-state facility.

3. Defendants are to have a CDCR mental health clinician conduct an additional screening of each inmates upon their arrival at the out-of-state facility in accord with the criteria stated in Special Master Keating's letter of November 1, 2006 (attached herein as Exhibit 1). The CDCR clinician is to be licensed by the State of California. Should the State of Tennessee not provide reciprocity for the California-issued licenses of these clinicians, this court hereby abrogates the State licensing requirements in regards this mandated screening of these 80 inmates by these clinicians.

4. Should the additional screening reveal any of the 80 inmates is not, under the criteria set forth by Special Master Keating, qualified to be transferred to this out-of-state facility, defendants are to ensure the inmate is immediately returned to the State of California when clinically safe to do so.

5. No other CDCR inmates are to be transferred to an out-of-state facility unless the screenings indicated in Special Master Keating's letter of November 1, 2006 are conducted in the State of California prior to transfer and the criteria for transfer indicated therein applied.

6. This matter is set for further hearing on Thursday, November 9, 2006, at 8:30 a.m. At the hearing, defendants shall report to the court on outstanding issues, including plaintiffs' request for additional clinical staffing of certain areas (such as administrative segregation-like units) of this out-of-state facility to provide mental health care to CDCR [3] inmates, and the status of implementation of applicable provisions of the Revised Program Guide.

7. At the further hearing, the parties shall also be prepared to discuss whether Special Master Keating or his designee should be directed to visit one or more of the out-of-state facilities with which CDCR has contracted and to report to the court on the adequacy of mental health care in those facilities.

DATED: November 6, 2006.

/s/ Lawrence K. Karlton
Lawrence K. Karlton
SENIOR JUDGE
UNITED STATES DISTRICT COURT

[Filed 11/06/06]

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VIA E-MAIL AND U.S. MAIL

November 1, 2006

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Re: *Coleman et al. v. Schwarzenegger et al.*,
No. CIV S-90-0520 LKK JFM P

Counselors:

My experts and I have received and reviewed the documentation on the screening process the defendants propose to use in screening inmates who have volunteered to be moved to prison facilities in other states to relieve overcrowding in CDCR. I also received Bruce Slavin's October 12, 2006 letter on the then still developing transfer plans.

Both of these documents indicated that CDCR intended to exclude from transfer anyone included in the Mental Health Services Delivery System, at least during the first phase of the transfers. Mr. Slavin's letter indicated, however, that, as the process evolved, the defendants would be willing to work with my experts to develop screening criteria for caseload inmates who might be able to transfer safely and receive appropriate treatment in another state.

Plaintiffs' counsel, meanwhile, express their legitimate concern that the exclusion of MHSDS inmates from the projected transfers will violate the Americans with Disabilities [2] Act of 1990, a concern that echoes issues raised in the recently filed *Hecker* suit, which seeks, among other remedies, the reversal of current CDCR policies excluding MHSDS inmates from some CDCR programs and housing based on their inclusion in the mental health caseload. That case is currently pending before Judge Karlton.

The imminent transfer of CDCR inmates to privately operated prisons in Arizona, Oklahoma and Indiana, which I understand is projected to begin in early November, precludes any meaningful opportunity to assess the standards, resources and capabilities for the provision of mental health care of the institutions earmarked to receive the first transferees. Moreover, the defendants have not yet provided for review the draft version(s) of contracts spelling out the terms of CDCR's engagement with the private providers, particularly any provisions related to the evaluation and handling of CDCR inmates transferred to contracted prisons, who subsequently develop serious mental disorders.

Meanwhile, my experts' critique of the screening process focused largely on whether, and which, *former* participants in the MHSDS might be considered for transfer. The experts unanimously agreed that transfers of former MHSDS inmates should be based on a case-by-case evaluation conducted by a mental health clinician that involves both a thorough record review and a personal interview. An inmate's suicidal history was viewed as a critical component of any such evaluation; recent and/or serious attempted suicides ought to preclude transfer. Incidental suicidal ideation or minor gestures committed long ago would not necessarily constitute a bar. Generally, only former 3CMS inmates should be considered for transfer; there should be a presumption against the transfer of former participants in EOP, PSU, MHCB and inpatient DMH programs. Inmates from such programs with a diagnosis of a severe and persistent mental illness, with any of the Axis I disorders enumerated in the Program Guide list or a prior Keyhea order, should not be considered for transfer in the absence of overwhelming countervailing clinical evidence. Finally, any decision to transfer ultimately depends on the adequacy of mental health services at the receiving institution.

The screening process described in the draft document pays too little attention to mental health screening, presumably on the presumption that inmates on the MHSDS caseload will not be transferred during this Phase I placement process. Once a screening is conducted, including both a UHR review and a face-to-face assessment by the R&R RN, anyone determined to raise mental health issues should be referred for a face-to-face evaluation by a mental health clinician (psychiatrist, psychologist or a psychological social worker) rather than, or in addition to, the PCP.

[3] My experts and I remain ready to cooperate with the defendants in the development of criteria for

the possible transfer of MHSDS caseload inmates out of state as the program unfolds. An additional concern is how best to determine the actual state of mental health services in the institutions designated for the receipt of CDCR inmates. In the meantime, I would appreciate the prompt provision of draft or final contracts regulating relations with the institutional vendors who will be receiving CDCR inmates.

Sincerely yours,

J. Michael Keating, Jr.
Coleman Special Master

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FOR ARGUMENT

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Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
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Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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NOTICE

The following documents have been omitted from the printing of this Deferred Joint Appendix. They may be found in the Appellants' Appendix to the 09-416 Jurisdictional Statement at the following pages:

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and in the Appellants' Appendix to the 09-1233 Jurisdictional Statement at the following pages:

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[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

Case No.: 2:90-cv-00520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Hearing Date: June 4, 2007
Time: 11:00 a.m.
Courtroom: 4, 15th Floor
Judge: The Honorable Lawrence K. Karlton

DEFENDANTS' SUPPLEMENTAL BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR REFERRAL TO A THREE-JUDGE PANEL

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DEFENDANTS' SUPPLEMENTAL BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR REFERRAL TO A THREE-JUDGE PANEL

INTRODUCTION

On May 4, 2007, this Court issued an order inviting the parties to file supplemental briefs and evidence to address any developments since this Court's December 12, 2006 hearing on Plaintiff's motion to convene a three-judge panel to limit population. At the time of the December 2006 hearing, Defendants described their steady progress in complying with court orders developing the elements of a constitutionally adequate system. Now, Defendants can point to landmark legislation and other aggressive efforts by the State to eliminate prison overcrowding and provide needed reforms.

[2] Assembly Bill 900 (AB 900) is a key development in Defendants' completion of an adequate mental health services delivery system. With AB 900, the Governor and Legislature approved a historic, bipartisan plan to reduce prison overcrowding, increase rehabilitation programs, and provide more beds for inmate medical care. AB 900 creates a comprehensive plan to immediately relieve overcrowding by providing for additional out-of-state inmate transfers. It is expected that approximately 8,000 inmates will be transferred by March 2009, and transfers will continue thereafter as needed, as AB 900 authorizes transfers until July 1, 2011. The bill provides for the construction of 40,000 prison beds, including much-needed mental health beds, and approximately 13,000 new jail beds. In addition, AB 900 provides for new rehabilitation programs and re-entry facilities to improve inmate re-entry into California communities, thereby reducing recidivism, easing prison overcrowding, and ensuring public safety. AB 900's comprehensive plan, along with the additional parole reforms implemented by the California Department of Correction and Rehabilitation (CDCR), will aggressively address prison overcrowding without encouraging or causing the early release of dangerous criminals.

But that is not all. California's prisons must be expertly managed and the prison reforms must be implemented immediately. Accordingly, the Governor has established two strike teams – one for construction and another for rehabilitation – to expedite construction and to create and improve programs for rehabilitation, substance abuse, education, and job training. Further, CDCR is immediately implementing administrative parole changes that reward successful rehabilitation, which will further reduce overcrowding.

This comprehensive, historic plan for prison reform will directly assist the Defendants in their efforts to provide constitutionally adequate mental health care. AB 900 provides for much-needed mental beds. During the implementation of these bipartisan prison reform efforts, work continues and will continue on the integral components of an adequate mental health services delivery system within the prison system: appropriate policies and procedures for mental health care, sufficient and qualified mental health care staff, accurate record and data management, and sufficient licensed and unlicensed beds for mental health patients. *Coleman v. Wilson*, 912 F. Supp. at 1298 n.10 (1995), citing *Balla v. Idaho State Board of Corrections*, 595 F. Supp. 1558, [3] 1577 (D. Idaho 1984). In this supplemental brief, Defendants show that they have already made significant progress, and that they will work aggressively to accomplish more.

Within this context, the Court now considers Plaintiffs' motion for a referral to a three-judge panel to limit California's prison population. It is undisputed that California's prisons are overcrowded, and that the overcrowding has created emergency conditions in at least 29 California prisons. But as this response shows, Defendants are already aggressively addressing overcrowding, and the State's efforts will provide more comprehensive reform than any prison cap ever could. Thus, the question is whether it is necessary and appropriate, applying the limited criteria of the

Prison Litigation Reform Act of 1995 (PLRA), to refer this matter to a federal three-judge panel at this time. The answer is no, because the criteria for referral have not been met. Plaintiffs cannot meet their burden to prove, by clear and convincing evidence, that crowding is a primary cause of the alleged mental health violations. And less intrusive means to provide relief are already being implemented, and Plaintiffs cannot establish that they will fail. Under the circumstances, this Court should not make a referral to a three -judge panel.

LEGAL STANDARD

The PLRA limits the referral of prison population issues to a three -judge panel. Before making a referral, the district judge must find:

> (i) the Court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and
>
> (ii) the Defendant has had a reasonable amount of time to comply with the previous court orders. (18 U.S.C. § 3626(a)(3)(A).)

Moreover, the broader statutory scheme requires that any prospective relief must be narrowly drawn, shall extend no further than necessary to correct the specific constitutional violation involved, and must be the least intrusive means necessary to correct the constitutional violation. 18 U.S.C. § 3626(a)(1). In addition, substantial weight must be given to any adverse impact on public safety. *Id.* Both the spirit and the language of the PLRA indicate referral to a three -judge panel is a matter of last resort.

[4] The PLRA also requires a nexus between the relief sought and the federal right at issue. A three-judge panel cannot issue a prisoner release order unless it finds, by clear and convincing evidence, that (i) crowding is the primary cause of the constitutional violation at issue, and (ii) no other relief will remedy the violation. 18 U.S.C. § 3626(a)(3)(E).

LEGAL ARGUMENT

I.

BECAUSE THE STATUTORY BASES FOR REFERRAL HAVE NOT BEEN MET, THE MOTION SHOULD BE DENIED.

The State is now embarking on groundbreaking efforts to reduce prison overcrowding and to increase inmate beds and programs. Plaintiffs cannot prove at this time that these new reform efforts will fail, and Defendants should be given the chance to succeed. These efforts will provide comprehensive reform and will avoid releasing dangerous criminals into the community.

In addition, this Court has already issued orders for less-intrusive relief, and Defendants are making significant progress. As the following summary establishes, Plaintiffs cannot show that the current efforts will necessarily fail.

1. *Appropriate Mental Health Care Policies and Procedures.*

With this Court's approval of the Revised Program Guide in March 2006, Defendants commenced training on the implementation of its policies and procedures. (Dec. McKeever, ¶ 4.) Training has now occurred on a system-wide basis with mental health clinicians. (*Id.*) The Revised Program Guide will continue to be the subject of in-service training, particularly as new staff are hired. (*Id.*)

The scope of mental health care has been expanded. Defendants' mental health system now reaches those inmates often most in need of mental health services: those just entering the prison system at Reception Centers. (Dec. McKeever, ¶ 5.) In compliance with this Court's March 2006 order, Defendants have launched, system-wide, Enhanced Outpatient Care at Reception Centers. (Dec. McAloon, ¶ 6.) This program addresses the needs of those prisoners who, upon entry into the system, are found to need mental health care. (*Id.* at 5.) Their numbers are higher and their needs often more critical than those of the general *Coleman* [5] population. In the overall inmate population, approximately 18% of inmates are in the mental health caseload. (*Id.* at ¶ 7.) In the Reception Center population, an even higher percentage of inmates are in need of immediate mental health services at the time of arrival because they have not had access to mental health care resources, particularly medication management, in the community. (*Id.*) These Reception Center inmate-patients are often severely decompensated. (*Id.*) With early diagnosis and intervention, these inmates are stabilized and transferred to appropriate beds. (*Id.* at ¶ 8.)

2. *Recruitment of Qualified Mental Health Care Clinicians.*

In the past year, this Court has issued several orders addressing the quality and quantity of mental health staff available to *Coleman* class members. (Orders, 3/3/06, 6/21/06, 8/11/06, 12/15/06, 2/7/07.) Defendants have not only complied with those system-wide orders, but have implemented steps beyond what was required. Defendants have undertaken efforts to expand the Headquarters staff at CDCR. The initial step of obtaining funding for only the mental health staffing necessary to implement the Revised Program Guide has been followed by significant increases in the salaries of CDCR and DMH clinicians system-wide.[1] Those salary increases have been paired up with a request for the Legislature to authorize $1 million in funding to support the recruitment of psychiatric and medical services staff within state institutions. (Def. Response to Ct. Order Regarding a Plan to Address Pay Parity with DMH Clinicians, filed 4/2/07.) In addition, the hiring of clinicians is about to be revamped by compressing the process for mandated hiring ranks to ensure a greater pool of 'reachable' candidates.[2] Defendants are also nearing completion of the court-approved process for the evaluation of the competency of [6] psychiatrists employed by CDCR. (Dec. McKeever, ¶ 7.) Defendants acknowledge the challenge of staffing the CDCR and DMH facilities serving the needs of mentally ill inmates and commit to monitoring the impact of these efforts.[3]

---

[1] Effective April 1, 2007, DMH will provide salary adjustments for incumbent staff in the Coleman classes working in state hospitals. DMH will fund the salary adjustments for the current year, April 2007 through June 2007, from salary savings and the budget year costs will be funded through the Spring Finance Letter and May Revision proposals that were submitted to the Legislature. The raises and resulting new salary ranges included in the Spring Finance Letter are subject to negotiations with the various bargaining units and approval by the Legislature. (Def. Response to Ct. Order to Address Staffing Vacancies Within DMH, filed 5/16/07.)

[2] At the hearing on CDCR's proposed resolution to compress the hiring ranks of certain mental health classifications, the State Personnel Board indicated approval of the resolution. (Dec. McKeever, ¶ 6.) CDCR awaits issuance of the resolution. (*Id.*)

Defendants are keenly aware of the integral role of DMH beds and services in delivering care to inmate-patients. They are working to remove the January 23, 2007 triaged admissions process at ASH by recruiting and retaining staff. Their plan to address the recruitment issues of the Department of Mental Health was submitted on May 16, 2007. (Def. Plan To Address Staffing Vacancies Within DMH, filed 5/16/07.) Defendants remain committed, as stated in that plan, to apprize the Court at three-month intervals of the efficacy of that plan.

3. *Sufficient Mental Health Care Beds for Mentally Ill Inmates.*

This Court is well-aware of the plans Defendants have submitted to address the mental health bed needs of mentally ill inmates. This Court has ordered several plans: acute and intermediate inpatient beds; mental health crisis beds; interim provision of intermediate inpatient and mental health crisis beds; and an amended long-term plan based on current population projections. (Orders, 3/3/06, 5/2/06.) Further, Defendants were ordered to coordinate their compliance efforts, particularly those involving bed planning, with the Receiver appointed on April 17, 2006 in *Plata v. Schwarzenegger*, USDC N.D. Cal. Case No. C01-1351 THE. (Order, 6/8/06.)

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[3] To the extent Plaintiffs rely upon any of the preliminary findings and recommendations stated in Special Master Keating's Seventeenth Round monitoring report, part C, Defendants hereby object to such reliance as premature and inappropriate. The information has not been subject to the the parties' review and response nor to final review by the Special Master and acceptance by this Court.

Under the amended long-term bed plan, Defendants stated their intent to construct sufficient mental health beds at consolidated care centers to serve the forecasted population of mentally ill inmates in 2011. (Def. Am. Long-Range Bed Plan, filed 12/19/06.) The key components of the plan were expressly stated:

> [7] i. Consolidate mental health care for male inmate-patients in five prisons identified as Consolidated Care Centers – California State Prison, Sacramento, Richard J. Donovan, California State Prison, Los Angeles County, California Institution for Men and California Men's Colony – while maintaining mental health programs at Salinas Valley State Prison and California Medical Facility;
>
> ii. Expand mental health beds for female inmate-patients at California Institution for Women;
>
> iii. Continue mental health bed expansion projects currently underway, where appropriate; and
>
> iv. Return mental health beds within state hospitals to Department of Mental Health (DMH) use, with CDCR assuming responsibility for the provision of acute and intermediate care beds and services for CDCR inmate-patients.

AB 900 also provides for mental health beds. (Dec. Hysen, ¶ 10.) The Facilities Construction Strike Team will ensure expedited construction, and the Governor's emergency powers will be utilized, as needed, to facilitate this effort. (*Id.* at ¶ 11.) With the implementation of bed construction under AB 900, this Court will be apprized of the coordination of bed-planning activities with those of the *Plata* Receiver. (Orders, 6/8/06, 10/20/06.) Defendants are confident the necessary beds and treatment space for the care of mentally ill inmates will be available.

Defendants also are ready to meet the short-term bed gap. To meet mental health care needs before the construction of new facilities, Defendants have activated or will soon activate additional Enhanced Outpatient Program and intermediate care beds as follows:

i. Mule Creek State Prison has activated 180 Level III Enhanced Outpatient Program (EOP) beds and an additional 115 Level IV EOP beds beginning in January 2007;

ii. The California Institute for Women activated ten psychiatric services unit (PSU) beds in January 2007;

[8] iii. Salinas Valley Psychiatric Program has already activated 18 intermediate care bed in the D5, C-pod and will activate 38 intermediate care beds in the A and B pods by July 30, 2007, with two additional intermediate care beds within D-6 under construction; and

iv. Vacaville Psychiatric Program is scheduled to activate 30 intermediate care beds in P-3 by June 29, 2007. (Dec. McKeever, ¶ 9.)

Defendants are committed to exploring with Special Master Keating other strategies to provide sufficient beds, including:

i. CDCR's removal of the four classification points accorded to inmates diagnosed as *Coleman* class members at reception, with the removal premised upon a showing of consistent non-violent programming by the inmate, would possibly enable some 1,300 *Coleman* class members within the CCCMS level of care to move into available Level I and Level II housing;

ii. The development of an appropriate plan, with review of the mental health policies and staffing of the selected facilities and review of the screening criteria, for the out-of-state transfer of certain CCCMS inmates;

iii. Ending the automatic use of intermediate care beds for the care of CDCR inmates who are found incompetent to stand trial for a CDCR-based offense, and instead assessing the individual inmate's clinical need for such care. This strategy would enable proper use of intermediate care beds; and

iv. Revising CDCR policies and regulations to permit, under certain circumstances, the suspension of certain security measures (e.g., SHU terms, close-custody status) to enable placement of high-custody inmate-patients requiring DMH inpatient care. (Dec. Kernan, ¶ 24.)

As with the staffing issues, Defendants remain committed to apprizing the Court at three-month intervals of the efficacy of the plans.

4. *Efforts to Address Suicide Issues Are Underway.*

Defendants worked closely with Special Master Keating's team and Plaintiffs' experts in preparing their submitted plan for addressing suicide trends in administrative segregation units. [9] (Order, 6/8/06; Def. Filed Plan, 10/2/06.) Upon receipt of objections to certain aspects of the plan, Defendants agreed to adopt many of Plaintiffs' recommendations. (Def.

Response to Plf. Objections, filed 12/1/06.) Even before this Court formally approved the plan, Defendants had already implemented portions of the plan, such as the commencement of thirty-minute welfare checks. (*Id.*) Since this Court's approval in February 2007, Defendants have performed other aspects of the plan, such as increasing the property allowance of inmates within administrative segregation units and retrofitting vent screens. (Special Master's Report on Ad. Seg. Plan, pp. 4-5, filed 5/14/07.) Defendants will continue to implement this plan and inform the Court of its efficacy. (Doug McKeever, ¶ 10.)

In sum, less-intrusive reform efforts are already underway, and Plaintiffs cannot prove that they are failing. These efforts can provide more targeted relief than the referral of this matter to a three-judge panel and the introduction of a population cap.

II.

ANY REFERRAL TO A THREE-JUDGE PANEL WOULD BE INAPPROPRIATE IN LIGHT OF DEFENDANTS' AGGRESSIVE, MULTI-PRONGED APPROACH TO OVERCROWDING.

Referral to a three-judge panel is inappropriate. Defendants are working aggressively to provide appropriate beds for the *Coleman* class members and increased salaries to enable staffing of those beds. (Def. Response 16th Monitoring Report (draft); Def. Am. Long-Range Bed Plan, filed 12/19/06; Def. Responses to Court Orders re. Pay Parity, filed 4/2/07, filed 5/16/07.) AB 900 also provides for mental health beds. The Governor has shown his commitment to reform. He called a special session of the Legislature, issued an Emergency Proclamation, initiated the transfer of inmates out of state, and pushed for passage of AB 900 in an extraordinary effort to address overcrowding and reform the prison system. AB 900 provides for the facility and program development necessary for a constitutionally adequate mental health care system, and the State should be given the opportunity to implement it.

[10] A. The State Is Taking Immediate and Dramatic Steps to Reduce Overcrowding, Including Transferring Inmates Out of State, Changing Parole Policies, Implementing Rehabilitation Programs to Reduce Recidivism, Building New Prison Space, and Appointing Management Strike Teams to Implement These Efforts.

The State is working on many fronts to reduce overcrowding in California's prisons. As an initial matter, CDCR will pursue using all in-state private prison beds, and will transfer inmates to those private beds to the extent they are available. (Kernan Decl., ¶¶ 3, 8.) And beginning in June 2007, CDCR will resume transferring inmates to out-of-state private prison facilities. (Kernan Decl., ¶ 8.) It is expected that CDCR will process up to 400 inmates per month for transfer out of state, and that approximately 8,000 inmates will be transferred by March 2009. (*Id.*) Transfers will continue thereafter as needed, as AB 900 authorizes transfers until July 1, 2011. In addition, the State will expedite construction of all AB 900 Phase I beds, as described below. Expediting construction will include waiving state laws, as needed, under the Governor's Emergency Proclamation. (Hysen Decl., ¶ 8.) It is expected that construction of 12,000 Phase I in-fill beds will be completed in 2009. (*Id.*, ¶ 7.)

CDCR is also making administrative changes to its parole policies, which will reduce overcrowding. In addition, CDCR will implement new rehabilitation programs that will reduce recidivism, again reducing overcrowding. Finally, to ensure that these reform measures are implemented aggressively and efficiently, two new managerial strike teams have been established, as more fully explained below. (Petersilia Decl., ¶ 1; Hysen Decl., ¶¶ 3, 6.)

1. *General Provisions of Assembly Bill 900.*

On May 3, 2007, Governor Schwarzenegger signed AB 900 into law. AB 900 will immediately reduce prison overcrowding by providing for additional inmate transfers to private out-of-state prison facilities. In addition, AB 900 will further address prison overcrowding by authorizing construction of in-fill beds (beds on grounds of existing prisons), establishing more community re-entry beds, and creating more medical and mental health beds. The medical beds will directly support the Receiver's efforts, and the entire comprehensive plan will quickly reduce, and eventually eliminate, the thousands of "non-traditional beds" that currently fill [11] common areas such as gymnasiums, day rooms, and program rooms.

Phase I of AB 900 provides for 7,484 in-fill beds at existing enumerated prisons, plus an additional 4,516 in-fill beds once site assessments have been done for other facilities, for a total of 12,000 Phase I in-fill beds. (Hysen Decl., ¶ 7.) AB 900 specifies that the purpose of the in-fill beds is to replace the non-traditional beds currently in use. Phase I also provides for 6,000 re-entry beds and 6,000 medical, dental, and mental health beds. (*Id.*) The construction of all Phase I beds will total 24,000 beds.

Phase II of AB 900 provides for an additional 4,000 in-fill beds; 2,000 medical, dental, and mental health beds; and 10,000 re-entry beds. The construction of all Phase II beds will total 16,000 beds. (Hysen Decl., ¶ 7.) However, AB 900 specifies that funds for Phase II construction shall not be released unless specific enumerated progress in construction, rehabilitation programs, management planning, and parole review has been confirmed by a panel consisting of the State Auditor, the Inspector General and an appointee of the Judicial Council of California. AB 900 also provides for construction of approximately 13,000 county jail beds. (Kernan Decl., ¶ 5.)

AB 900 ties prison bed construction to rehabilitation, requiring that each new bed have appropriate programming for inmates, including education, vocational programs, substance abuse treatment programs, employment programs, and pre-release planning. These programs will address overcrowding by reducing the recidivism rate. California currently has one of the highest recidivism rates in the nation. (Petersilia Decl., ¶¶ 6, 7.) This high recidivism rate increases overcrowding in California's prisons.

AB 900 also requires CDCR to develop and implement, by January 15, 2008, a plan to address management deficiencies within the department. Among other things, the plan must address (1) filling vacancies in management positions, (2) improving accountability, (3) standardizing processes to improve management, (4) improving communications within the Department, and (5) developing and implementing more comprehensive plans for management of the prison and parole populations. AB 900 authorizes CDCR to contract with outside management experts to assist in identifying and addressing deficiencies.

[12] 2. *Expert Strike Teams Will Improve Prison Management and Ensure Expedited Implementation of AB 900.*

The management assessment and plan required by AB 900 is not the Defendants' only tool for addressing management and administrative concerns. Governor Schwarzenegger has already established two expert strike teams – one for facilities and one for rehabilitation – composed of numerous experts from universities, community organizations, and state government to ensure that California's prisons are managed effectively and that bed construction and rehabilitation programs are implemented expeditiously.

(Petersilia Decl., ¶ 5; Hysen Decl., ¶ 6.)

The Facilities Construction Strike Team will restore CDCR's major project management capability and will work to expedite in-fill, re-entry, medical/dental/mental-health, and jail beds authorized by AB 900. (Hysen Decl., ¶ 6.) The Facilities Construction Strike Team will (1) consider all available options for housing inmates and improving inmate housing, (2) evaluate alternative construction methods, (3) work to overcome impediments to expedited construction, and (4) work with local communities impacted by prison facilities. (*Id.* at ¶ 12.)

At the same time, the Rehabilitation Strike Team will provide expertise on creating and expediting the implementation of rehabilitation programs. Such programs are integral to increasing successful community re-entry and reducing recidivism. The Rehabilitation Strike Team will be responsible for (1) assessing existing CDCR rehabilitation programs and space, (2) designing an integrated rehabilitation services delivery plan for inmates and parolees which includes substance abuse treatment, education, job training, counseling, and life skills, (3) developing a plan for inmate job training, (4) quickly implementing inmate intake and prerelease needs assessment tools, (5) developing incentives for program participation; (5) developing a plan to immediately reduce the number of lockdown days so that inmates can participate in rehabilitative programming; and (6) developing the $50 million in rehabilitation and treatment funds that are authorized by AB 900. (Petersilia Decl., ¶ 4; Jett Decl., ¶ 4.) The Rehabilitation Strike Team expects to reduce recidivism by 10%, which would eliminate 8,100 [13] prison returns in a single year. (Petersilia Decl., ¶ 10.)

3. *AB 900 Allows Out-of-State Transfers of Inmates and Dovetails With Other State Efforts to Reduce Prison Overcrowding.*

a. *Out-of-State Transfers Will Continue With Passage of AB 900.*

The out-of-state transfer of inmates will be recommenced in order to quickly reduce overcrowding in California prisons statewide. The Governor issued an Emergency Proclamation in October 2006 to permit transferring consenting inmates to out-of-state facilities. That Proclamation resulted in the current housing of some 360 inmates in out-of-state facilities. (Kernan Decl., ¶ 8.) CDCR will now continue the transfer process starting in June 2007. (*Id.*) CDCR will initially transfer up to 300 inmates per month for the first four months, and then increase the transfers to 400 inmates per month. (*Id.*) It is anticipated that this rate of transfer will continue through the end of fiscal year 2007/2008. (*Id.*) Under this plan, 5,060 inmates will be transferred to out-of-state facilities by the end of June 2008, and 8,000 inmates will be transferred by March 2009. (*Id.*) After March 2009, transfers will continue as needed because AB 900 authorizes continued transfers until July 1, 2011. (*Id.*)

These out-of-state transfers will reduce the number of non-traditional beds from approximately 18,000 to approximately 13,000 by the end of the 2007/2008 fiscal year. (Kernan Decl., ¶ 8.) CDCR will pursue all in-state transfer opportunities before initiating out-of-state transfers to the extent possible. (*Id.*) Inmates selected for transfer to out-of-state facilities will undergo a comprehensive medical, mental health and custodial screening. (*Id.* at ¶ 12.) Only those inmates who meet approved medical and mental health criteria will be selected for transfer.

Transferring inmates to out-of-state facilities will reduce prison overcrowding and enable correctional officers and health care staff to better serve the inmates. (Kernan Decl., ¶ 12.) To the extent overcrowded prisons create tense living environments with greater incidents of violence, a reduction in prison overcrowding will reduce the tension and decrease incidents of violence. (*Id.*)

b. *The In-Fill Beds Provided by AB900 Will Reduce Crowding.*

AB 900 will also reduce prison overcrowding by authorizing the construction of 16,000 [14] in-fill beds. (Hysen Decl., ¶ 7.) In-fill beds will provide additional capacity at existing prisons in a way that ensures proper facilities, support, and services. (*Id.* at ¶ 8.) Creating in-fill beds will not require the construction of new prisons; rather, there will be construction of new facilities at existing prisons. (Kernan Decl., ¶ 13.) In-fill beds, like the out-of-state transfer of inmates, will eliminate non-traditional beds and provide better care and services for inmates. The Facilities Construction Strike Team will expedite construction. (Hysen Decl., ¶ 11.) As required by AB 900, these beds will be constructed to fully integrate rehabilitative programs into the new facilities. (*Id.* at ¶ 8.) The Facilities Construction Strike Team will work to finish construction as quickly as possible, but at a minimum it is expected that construction of the 12,000 Phase I in-fill beds will be completed in 2009. (*Id.* at ¶ 8.) As new in-fill beds are constructed, AB 900 mandates the reduction in a proportionate number of non-traditional beds until non-traditional bed use is entirely eliminated. (Kernan Decl., ¶ 13.)

c. AB 900 Re-Entry Beds Will Enhance Rehabilitation and Successful Return to Society.

AB 900 also provides for the creation of 16,000 re-entry beds. The focused of the reentry beds is to provide rehabilitation services and prepare inmates for re-entry into society. (Kernan Decl., ¶ 14.) These beds will be located in small, secured facilities (500 inmates maximum per facility) operated by CDCR. (*Id.*) The facilities will be located close to established communities to better serve their rehabilitative and re-entry mission. (*Id.*) The Facilities Construction Strike Team will expedite the construction of 6,000 Phase I re-entry beds. (Hysen Decl., ¶ 9.)

d. AB 900 Addresses the Construction of Mental Health Beds.

The Facilities Management Strike Team is aware of Defendants' amended long-term bed plan of December 19, 2006, with its aim of meeting the forecasted *Coleman* population of 2011. (Dec. Hysen, ¶ 14.) AB 900 states that a total of 8,000 medical/mental health beds will be created. The Facilities Construction Strike Team will expedite construction of these beds to bring them on line as soon as possible. (Hysen Decl., ¶¶ 10, 11.) Based on the scope of the *Plata* Receivership, construction of the AB 900 medical and mental health beds will require [15] coordination with the Receiver. (Kernan Decl., ¶ 15.)

4. *Administrative Parole Changes.*

Parole reform strategies will also play a large role in the reduction of prison overcrowding. In tandem with the implementation of AB 900, CDCR has launched a set of parole changes to reward successful rehabilitation. (Kernan Decl., ¶¶ 16-20.) CDCR is actively pursuing strategies to release parolees from their statutory parole periods as soon as is appropriate. (Kernan Decl., ¶¶ 16-22.)

a. *Timely Discharge From Parole In Accord With State Law*

By way of background, current California law provides for the timely discharge of parolees from parole so long as they have successfully programmed for a certain time on parole. Under California Penal Code section 3001, those parolees initially released from prison after serving time for a non-violent offense, and who have complied with the terms of their parole continuously for one year after their release, shall be discharged on the 30th day after their first year of parole (or at the 13th month of their parole term), unless the recommendation to retain them on parole has been made to, and approved by, the Board of Parole Hearings. (Cal. Penal Code § 3001.) Similarly, parolees initially released from prison after serving time for a violent offense and who have complied with the terms of their parole continuously for two years since their release, shall be discharged the 30th day after their second year of parole (or at the 25th month of their parole term), unless the recommendation to retain has been made to, and approved by, the Board of Parole Hearings. (Kernan Decl., ¶ 18.)

A review of the practices of the Division of Adult Parole Operation (DAPO) showed fewer parolees being discharged from parole at the 13th and 25th months than is allowed by California Penal Code section 3001. On May 15, 2007, DAPO issued a memorandum clarifying when parolees must be released from parole under this state law. (Kernan Decl., ¶¶ 18, 22, Ex. B.) The memo reflects the language of Penal Code section 3001. (*Id.*) Historically, DAPO discharged approximately 13,800 parolees annually at the 13th month, and 5,000 at the 25th month. With the issuance of this clarifying memorandum, it is anticipated that there will be an [16] additional discharge of between 2,000 and 4,000 parolees from parole in the next twelve months. (Kernan Decl., ¶ 18.) By discharging more parolees from supervision, CDCR expects to experience a reduction in the number of parolees returned to custody for various parole violations.

b. Implementation of Risk and Needs Assessment Tool and Decisionmaking Matrix.

Further, the Division of Adult Parole Operations (DAPO) implemented a risk and needs assessment tool in each of the 33 institutions: the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS). (Kernan Decl., ¶ 19.) A study is currently being conducted to evaluate the predictive validity of COMPAS in terms of its ability to effectively identify key risk and needs factors in the parole population. (*Id.*) Additionally, DAPO has undertaken extensive research into the use and effectiveness of a parole-violation decision-making matrix with the support of corrections expert Dr. Joan Petersilia and other topic area experts. (*Id.*, ¶ 20.) This tool has been shown to improve organizational decision-making consistency, as well as help to establish a culture of determining sanctions based on policy-driven rationale and then tailoring the sanction to the specific risk and needs of the parolee. (*Id.*) When supported by evidence-based programs, such as COMPAS, this type of matrix has been proven to play a meaningful role in the overall reduction of recidivism rates among the parolee population. (*Id.*) DAPO anticipates that a decision-making matrix will be ready for a pilot deployment by the end of 2007. (*Id.*) Once implemented, these tools will result in even more discharges from parole. (*Id.*)

B. Although the Current Prison Population Exceeds 174,000 Inmates, the State's Prison Reform Plans Will Dramatically Reduce Overcrowding.

Approximately 162,848 male and 12,141 female inmates are currently housed by CDCR, for a total prison population of approximately 174,989 inmates.[4] (Kernan Decl., ¶ 6.) CDCR [17] anticipates housing in-state 164,599 male inmates in March 2008, and 167,614 male inmates in March 2009. (*Id.*

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[4] Defendants provide this information in light of this Court's direction to Special Master Keating to provide a report indicating, in part, the current inmate population in the California Department of Corrections and Rehabilitation; and the current size of the Plaintiff class. (Order, 5/18/07.)

at ¶ 23.) With the re-commencement of out-of-state transfers and the anticipated impact of timely discharging certain parolees from parole, in accord with Penal Code section 3001, those anticipated numbers of CDCR inmates housed in-state will decrease to 159,939 male inmates in March 2008, and 162,674 male inmates in March 2009. (*Id.*) Defendants anticipate that other parole reduction strategies discussed above, such as alternative programming, the COMPAS risk and needs assessment tool, the decision-making matrix, and alternative sanctions programs, will further decrease CDCR's in-state male prison population.

Within the overall population, the population of Coleman class members now totals some 32,667. The population by level of care is as follows[5/]:

LEVEL OF CARE	POPULATION
Correctional Case Management System (CCCMS)	27, 982
Enhanced Outpatient Program (EOP)	4, 031
Psychiatric Services Unit	320
Mental Health Crisis Bed	270
Inpatient Intermediate Care (ICF)	316
Day Treatment Program	38
Inpatient Acute Care (APP)	101

(Decl. McKeever, ¶ 11.)

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[5] These stated population numbers are current as of May 11, 2007, for all levels of care, except: (a) the population numbers for Intermediate Care, Day Treatment, and Acute are current as of May 16, 2007 and (b) the population number for Mental Health Crisis Bed is current as of May 14 2007

III.

A POPULATION CAP IS AN OVERLY INTRUSIVE REMEDY AND WOULD NOT BE NARROWLY TAILORED TO TARGET RELIEF FOR THE *COLEMAN* CLASS BECAUSE PLAINTIFFS CANNOT PROVE THAT OVERCROWDING HAS CAUSED THE DEFICIENCIES IN MENTAL HEALTH CARE.

A prisoner release order cannot issue unless Plaintiffs prove, by clear and convincing [18] evidence, that crowding is the primary cause of the lack of constitutional mental health care, and that no other relief will remedy the violation. 18 U.S.C. 3626 (a) (3) (e). Here, Plaintiffs cannot meet their burden because the evidence establishes that the problems with the mental health care system are primarily administrative problems. This Court has recognized this fact, and its prior orders have been targeted to address training, staffing, salaries and bed planning. These orders are the less intrusive ways to provide relief, and Plaintiffs cannot prove that they have failed.

There is no direct nexus between meeting the treatment needs of the *Coleman* population and capping the overall population of CDCR. Although a reduction in prison overcrowding will improve the prison environment, the provision of constitutional mental health care requires increased mental health beds and mental health staff to provide necessary care. That staff must be well-managed, well-paid, and well-trained. A cap on the population will not ensure this. But this Court's less-intrusive, targeted orders in combination with the State's landmark reform efforts will make a significant difference. More beds will be created under the aegis of AB 900 through expedited construction processes. Bed construction will require coordination with the Receiver, but the Receiver urged the *Plata* court to allow his Plan of Action to be implemented without the overlay of population cap proceedings and determinations, observing those who think that population controls will solve California's prison health care problems, are simply wrong. (Receiver's Report re Overcrowding at 42-43.) The *Coleman* Defendants likewise now have a set of plans, embraced within AB 900, and request the Court to allow them to engage fully in those plans without the need to address another set of proceedings and remedies in another forum.

When considering the nexus between population and mental health care, this Court cannot make a referral to a three judge panel unless that panel could order relief that would clearly assist Defendants in the delivery of constitutional mental health care. Defendants are already making great progress to address prison overcrowding and to provide constitutional mental health care to inmates. A prison population-cap order could not provide the comprehensive reform that the Defendants are already implementing. Referral to a three judge panel will not provide immediate overcrowding relief, and an order issued by a three judge panel [19] could not ensure efficient management, adequate mental health care, or public safety. A far better course is to allow Defendants to implement their comprehensive reform plans.

CONCLUSION

Defendants are launching an aggressive and comprehensive plan to reduce overcrowding in California's prisons. AB 900 provides for out-of-state transfers, thousands of mental health beds, and better rehabilitation programs to reduce recidivism.

Expert strike teams have been established to expedite implementation and ensure effective prison management. Administrative parole changes have been implemented to further reduce overcrowding. These landmark and deep-reaching changes in housing, rehabilitation, and parole policies constitute the integrative approach necessary to create a properly working prison system. At the same time, Defendants have embarked upon court-approved plans addressing the key features of an adequate mental health system. Just as this Court allowed Defendants sufficient time to prepare this integrative approach, so it should allow Defendants sufficient time to implement it. Accordingly, referral to a three judge panel is not appropriate.

Dated: May 24, 2007

Respectfully submitted,

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[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

SPECIAL MASTER'S RESPONSE TO COURT'S MAY 17, 2007 REQUEST FOR INFORMATION

On December 11, 2006 Plaintiffs, through their counsel, moved for an order to convene a three-judge panel to limit the prison population pursuant to 28 U.S.C. §2284 and 18 U.S.C. §3626(a)(3). On December 12, 2006, the Court heard initial arguments on the motion and continued the matter for further argument on June 4, 2007. On May 3, 2007, the Court ordered the parties to file supplemental briefs on or before May 24, 2007. On May 17, 2007, the special master was ordered to provide, on or before May 31, 2007, the following information to the Court:

> "(1) The current inmate population in the California Department of Corrections and Rehabilitation (CDCR);
>
> (2) The current size of the plaintiff class;
>
> (3) What percentage of the plaintiff class is being provided with necessary mental health services

with presently available resources, including but not limited to staff, beds, and programming space; and

(4) Whether a reduction in total inmate population will affect the answer to question number (3) and, if so, what level of total inmate population reduction [2] would be required to allow the provision of constitutionally adequate care to all members of the plaintiff class." (See order dated May 17, 2007.)

In response to the Court's May 17, 2007 order and its specific queries, the special master responds as follows:

I. *Current inmate population*

As of May 11, 2007, approximately 162,848 male and 12,141 female inmates were housed in CDCR facilities, for a total prison population of 174,989 inmates. (Defendants' Supplemental Brief in Opposition to Plaintiffs' Motion for Referral to a Three-Judge Panel, May 24, 2007.) These figures, like the population numbers submitted in the *Plata* receiver's report on the impact of overcrowding on healthcare services, are based on the defendants' spring 2007 population projections and are approximations. (See Exhibit A.)

II. *Current size of the plaintiff class*

In response to a request for information, defendants reported the size of the California Department of Corrections and Rehabilitation's (CDCR's) Mental Health Service Delivery System caseload as of May 25, 2007 to be 32,958. (See Exhibit B, at p R-4.) That figure represents slightly less than 19 percent of the total inmate population. The population count provided by defendants was broken down as follows:

Level of Care	Population
Correctional Clinical Case Management System (3CMS) for outpatient inmate/patients housed in the general population:	28,154
Enhanced Outpatient Program (EOP) for outpatient inmate/patients housed generally in separate residential units:	4,054
[3] Psychiatric Service Units (PSUs) for outpatient inmate/patients requiring a high level of custody at an EOP level of care:	301
Department of Mental Health (DMH) programs for inmate/inpatients in need of acute or intermediate inpatient treatment	449

The figures and the accompanying breakdown omit some important elements of the caseload, including inmate/patients referred for a Mental Health Crisis Bed (MHCB) level of care because they are suffering from severe decompensation or are a danger to themselves or others. A substantial proportion of these inmate/patients are at a high risk for suicide. They are typically housed in a MHCB unit, where they can receive around-the-clock monitoring and intensive case intended to stabilize them for return to CDCR's less intensive outpatient programs. Over the past three years, however, the number of inmate/patients referred to a MHCB level of care has regularly and significantly exceeded the number of MHCBs available in CDCR, resulting in the placement of inmate/patients in need of a MHCB level of care in a variety of temporary housing alternatives, which often lack the heightened monitoring and treatment essential to the MHCB level of care. These alternative placements include Outpatient Housing Units (OHUs), which are infirmaries for the temporary housing of inmate/patients with minor illness or awaiting transfer within 72 hours to a licensed facility elsewhere; Mental Health Outpatient Housing Units, recently developed specifically to provide temporary housing, also for up to 72 hours, for mental health inmate/patients awaiting transfer to a MHCB; and a variety of other structures ranging from clinical holding cells to administrative segregation cells to telephone-booth-sized interview stalls typically placed in corridors. Most of these alternative placements lack suitable staffing and/or the physical configuration needed for [4] the continuous monitoring or intensive treatment provided in a MHCB unit. While strict time limits on their use are prescribed in both departmental and local policies, they are not consistently observed.

Because required records on the use of these alternative placements are poorly maintained in many institutions, it is difficult for defendants to provide accurate figures on the number of inmate/patients confined in them from day to day. Between MHCBs, OHUs, MHOHUs and other alternative placements, some 300 to 350 seriously mentally ill inmate/patients are confined in one or another of these facilities on any given day, but are not included in the tally provided above. Another anomaly in defendants' caseload calculation is the exclusion of some 35 female inmate/patients in DMH inpatient acute and intermediate programs at Patton State Hospital.

Inclusion of these two categories would bring the total mental health caseload to approximately 33,300 inmate/patients.

III. *Percentage of the plaintiff class being provided with necessary mental health services with presently available resources, including but not limited to staff, beds and programming space*

The Court's focus on three basic resources, each absolutely essential for the provision of adequate mental health services, reflects the knowledge accumulated in the long struggle to remedy the faults so glaringly revealed in the trial of this case in the mid-1990s. All three resources are critical, and each has been impacted seriously by overcrowding.

Programming space: The *Plata* receiver traces defendants' lack of adequate "clinical" space to design decisions made in the 1980s to address proactively anticipated overcrowding by planning to over-build only some limited and essential [5] functional areas of the new prisons, not including clinical healthcare space, to accommodate as much as 130 percent of overcrowding. At the same time, the infrastructure, including just water, wastewater, electrical and mechanical components, needed to meet anticipated overcrowding of as much as 190 percent in cells and 140 percent in dormitories was also incorporated in the design of the new facilities. No provisions were included for a similar expansion of clinical space for healthcare beyond the initial 100 percent of capacity. The receiver concludes that, however defendants care to characterize the general level of current overcrowding, "the available clinic space is *one half of what is necessary for daily operations*." See *Receiver's Report Re Overcrowding*, Plata v. Schwarzenegger, May 17, 2007, at p. 20ff (italics in the original).

That decision may, indeed, have left the medical side of healthcare with just half a loaf of needed clinical space. The cost to future mental health programming space was even greater. In 1988, when those decisions were reached, defendants were still several years ahead of the mental health catastrophes that eventually exposed the utter dearth of mental health services provided in CDCR's prisons. Not until 1993 did the defendants even begin to concede that some 7.9 percent of the CDCR population might conceivably require some form of mental health treatment. None of the 19 CDCR institutions planned and built in the boom of the 80s and 90s gave any thought to the space that might be needed for mental health purposes. Instead, as the need for much expanded mental health care and the space needed to provide it emerged in the mid and late 1990s, medical and mental health practitioners in CDCR were left to scramble for the clinical space originally designed to meet just half of anticipated medical needs alone.

[6] Clinicians' offices, any sort of interview space, locations for the conduct of group treatment, all were hopelessly inadequate. In secure environments, like administrative segregation units, Secure Housing Units or any locked-down unit, many, if not most, clinical interviews between clinicians and inmate/patients had to occur at cell-front or in those telephone-booth-sized holding cells, known among inmate/patients as "cages," in the corridors of living units in full view and hearing of correctional officers and other inmates. Group therapy, as often as not, was conducted, even in intensive care programs like EOP and PSUs, in dayrooms largely devoid of confidentiality, often surrounded by eavesdropping and kibitzing fellow inmates.

Improvement has occurred over the past dozen years, as the inadequacy of program and treatment space became clearer and the Court more insistent. Trailers began to appear at institutions to provide offices for clinicians to work in; limited all-purpose rooms were more often made available for therapeutic group activities; portions of structures were reconfigured to provide interview and counseling space; and, finally, at California State Prison at Sacramento, a huge new programming facility full of interview cubicles, clinical workers' offices and multiple-sized treatment activity rooms, was constructed and is now being activated. But elsewhere, finding appropriate space for the delivery of individual and group counseling in many units remains incredibly difficult. Each succeeding compliance report over the past two years, for example, has documented the decline in the number of hours of therapeutic activities offered in most institutions to Enhanced Outpatient Program inmate/patients in administrative segregation units, repeatedly attributed to the acute absence of adequate space.

[7] The growing problems reflect the impact of overcrowding. The sheer number of inmates needing all sorts of time out of their cells for all sorts of reasons puts incredible pressure on available space. When gyms, dayrooms and all-purpose rooms are filled with bunks and inmates, past accommodations for the use of these spaces for group activities for mentally ill inmates evaporate. The struggle for acquisition of a meaningful portion of healthcare clinical space, already able to meet just half the medical demand, escalates relentlessly. Access to space, moreover, is aggravated further by the growing dependence on increasingly less available escort correctional officers, who must regularly steer high

custody inmate/patients through the physical security barriers to interview and other treatment space. Excessive population, thus, results in a reduction of programming space now occupied by inmate bunks, greater competition for use of the diminishing available space; fewer escorting correctional officers to permit access to the diminishing space; and, ultimately, the increasing frustration and demoralization of clinicians trying to provide the treatment. The lack of programming space is a huge problem.

Obviously, of course, it is not just the lack of programming space that defines the problem. The inevitable result of severe overcrowding is that everyone also spends more and more time in their cells. General yards are more crowded, less well supervised and increasingly dangerous. There are not nearly enough walk-alone yards to provide statutorily required amounts of exercise for those who by choice or need require them. Gyms are no longer an option for time out of one's cell. Dayrooms share many of the same problems. Work or vocational opportunities shrink in the expanding population. Disturbances occur more frequently, with resulting increases in the number and duration of lockdowns. All inmates must spend increasingly larger chunks of their days in their [8] cells, or much more dangerously, in one of those triple-bunked "non-traditional" spaces. None of this is conducive to the health and well-being of any inmate, much less a seriously mentally disordered inmate/patient; it inevitably escalates the incidence of mental illness and exacerbates the condition of those already mentally fragile and vulnerable.

Beds: This Court has spent the last three years deeply immersed in the disconnect between the number of beds needed by defendants to provide mental health treatment for CDCR's most seriously mentally ill inmates and the beds available to provide such care. Indeed, the process of defining defendants' needs for such beds goes back nearly a decade to 1998, when it was discovered that the Department of Mental Health (DMH), CDCR's selected contractor for providing inpatient acute and intermediate care, had no facilities of its own in which to provide the level of inpatient care needed by CDCR for its high custody inmates with a history of violence or escape. This led, in turn, to a seemingly endless debate between the agencies over DMH's persistent claim it had, or would shortly have, all of the beds CDCR needed for its high security inmate/patients, punctuated by revelations to the contrary.

Eventually, after many stalled and ineffectual efforts to determine accurately the extent of the need for different levels of mental health care at the various custody levels, defendants finally obtained competent consulting help to develop reasonably reliable population projections for each treatment and security level, out of which eventually emerged plans for developing sufficient beds for high custody intensive inpatient mental health programs within secure CDCR institutions. Sadly, construction of the beds identified as needed to meet defendants' projected needs for acute and [9] intermediate inpatient care will not be completed until FY2011/12. The issue is further complicated by the defendants' plan to have CDCR, with its shaky history of providing just outpatient mental health care, undertake to deliver the inpatient care now delivered by DMH.

Similarly, defendants cannot expect to meet fully their projected need for beds for inmate/patients in general population Enhanced Outpatient Programs, administrative segregation EOPs, Psychiatric Service Units and Mental Health Crisis Beds until FY 2011/12. Overcrowding may not be entirely responsible for some of the specifics of this problem. Shifts in the nature of the mental health population, with increasing numbers of high custody inmates requiring EOP and inpatient acute and intermediate levels of care, seem to be driving the expansion of some categories of inmate/patients and the contraction of others. Whatever the cause, defendants are facing a four to five-year gap in the availability of sufficient beds to meet the treatment needs of many inmate/patients, who in the meantime are left suffering. This means that, nearly 12 years after the determination that mental health services in CDCR were egregiously unconstitutional, hundreds certainly, and possibly thousands, of CDCR inmates/patients, all members of the *Coleman* class certified in the early 1990s, are still looking for beds at the level of treatment their mental illness requires.

The inadequacy of beds appropriate to the treatment needs of inmates, particularly at the highest level of treatment needs, is compounded by severe overcrowding. The back-up of inmate/patients awaiting transfer to inpatient DMH programs fills MHCB units, which, in turn, cannot provide crisis intervention to other inmate/patients who need to be stabilized. The failure to stabilize the latter means more [10] of them will eventually need to be referred for inpatient care, and the unmet needs spiral higher and higher. Not surprisingly, harassed clinicians often choose not to undertake the frustrating struggle for a referral that will not bring movement for weeks or months, and increasing numbers of truly psychotic inmate/patients are trapped in EOPs that cannot meet their needs. In all of this, many of the clinical advances in CDCR's mental health system painfully accomplished over the past decade are slip-sliding away.

Staff: From the initiation of the remedial process in the *Coleman* case, the parties, the special master and the Court have all recognized staffing as the absolutely essential ingredient for defendants to meet their obligations and resolve the suit. For a while, back in 2002 and 2003, defendants, with aggressive contracting, were able to reduce functional vacancies among clinicians to acceptable levels, and hopes of eventually ending *Coleman* actually blossomed. In July 2003, the functional vacancy rate among psychiatrists was just two percent, while the same rate among case managers was 2.2 percent. The functional vacancy rate among psychiatric technicians was highest among clinicians at 7.7 percent. *Twelfth Monitoring Report of the Special Master on the Defendants' Compliance with Provisionally Approved Plans, Policies and Protocols*, dated December 8, 2003, at pp. 225,226.

The intervening years have been marked by substantial additions of allocated clinicians to meet higher standards of care for the expanding relative size of the mental health caseload within the steadily rising overall population. But, here again, the growth of the resource has not matched the rise in demand, and earlier gains have dissipated. As of April 30, 2007, vacancy rates among allocated positions for [11] psychiatrists, case managers (including psychologists and psychiatric social workers) and psychiatric technicians hovered in the mid-40 percent range (See Exhibit C):

Position	Allocations	Vacancies	Vacancy Rate
Psychiatrists	310.65	134.90	43.43 %
Case Managers	1,002.38	441.44	44.04 %
Psych Techs	498.36	219.52	44.05 %
Total:	1,811.39	795.86	43.94 %

With use of independent contractors, CDCR reduced the functional vacancy (the number of clinicians available after vacancies are subtracted from allocations and contracted services are added) among psychiatrists to 6.25 percent; among case managers to 23.84 percent; and among psych techs to 20.36 percent. (See Exhibit D.) The overall functional vacancy rate among mental health clinicians in April 2007 was 19.86 percent.

While CDCR's ability to fill allocated mental health positions has diminished, the mental health caseload population continued to expand, reaching as indicated above, some 33,300 inmate/patients. The capacity of defendants' Mental Health Services Delivery System is 29,314, which means that the actual census exceeds capacity by some 3,986 inmate/ patients or 13.59 percent. "Capacity" in this context refers primarily to the availability of clinical staff to provide the level of care required for each category of mental health care. When the functional vacancy rate among clinicians of 19.86 percent is added to the 13.59 percent surplus of inmate/patients over capacity, CDCR ends up with sufficient staff to provide full mental health services to roughly two-thirds of its mental health caseload or two-thirds of required services to its full caseload, [12] or, probably more realistically, some combination of reduced services to some segments of the caseload that can be covered with a third less clinicians than required.

The staffing figures also mean that 39.65 percent of all psychiatric services in CDCR in April 2007 were provided by contractors, as were 26.5 and 29.7 percent, respectively, of all case managers and psychiatric technicians' services. For lots of reasons, including the length and duration of provided services and problems of selection, orientation and supervision, contracted services are not the equivalent of services provided by full-time clinical employees.

Nor is this the full measure of defendants' mental health staffing deficiencies. The staffing situation among mental health managers and staffing personnel at the Division of Correctional Health Care Services headquarters in Sacramento is even worse. A substantial and much-needed allocation of staff in mid-2006 raised the number of mental health headquarters positions to 129. As of early 2007, the vacancy rate among those positions was a devastating 70 percent. This means that, to a large extent, the management and leadership for mental health services must be provided at the institutional level.

This discussion does not even address the endemic shortages of escort correctional officers, nursing staff, clerical and records keeping personnel, pharmacy staff and lab technicians described more appropriately and fully in the *Plata* receiver's report.

Given the inadequacies of programming space, program beds and mental health staffing, it is clear that a significant portion of the MHSDS caseload is not receiving the necessary mental health services spelled out in the revised Program Guide and accepted by the parties and Court as the measure of constitutionally adequate [13] services. Quantifying accurately the precise percentage of the caseload whose services are inadequate is more difficult. In the first place, the inadequacies described herein are not spread evenly throughout CDCR. The actual and cumulative impact of all these inadequacies in any particular institution depends on the facility's physical location, history, local overall and mental health leadership and other imponderable factors, such as the adequacy of the pool of mental health clinicians available in California to fill the ever expanding needs of CDCR and DMH.

Most prisons with large complex mental health caseloads and programs handle staffing shortages by assigning the bulk of clinical resources to programs providing the most intensive care and using whatever may be left over to staff the larger population with the lightest treatment needs in the outpatient 3CMS program. The risk is that the scarcity of services for these inmate/patients will eventually generate greater demand for the more intensive programs. In other facilities, especially those without MHCB units, local mental health administrators must struggle to find adequate beds, housing and treatment resources for seriously mentally ill inmates, often suicidal, who cannot be placed in the MHCB environment they need. The scarcity of MHCB, EOP and inpatient DMH beds mean long waiting lists for admission, usually in the only local beds where such inmate/patients can be kept, but at the expense of other local inmate/patients with needs of their own.

It is difficult, then, to place any precise quantitative label on the extent of unmet mental health needs. Suffice it to say that 11 years and five months after the Court found mental health services in CDCR to be unconstitutional in December 2005, a period of time, incidentally, more than five times the average length of incarceration of CDCR [14] inmates (27 months), defendants cannot meet at least a substantial portion, amounting in some loose amalgam to about 33 percent, of acknowledged mental health needs with current staffing resources. Insufficient intensive mental health treatment beds and a chronic lack of programming space for mental health treatment contribute further to defendants' inability to meet required mental health services. All three deficiencies are unquestionably exacerbated by overcrowding.

IV. *Effect of a reduction of total inmate population on answer to question number (3) and level of total inmate population reduction required to provide constitutionally adequate care to all members of the plaintiff class.*

From all of the foregoing, it is easy to conclude that defendants' ability to provide required mental health services would be enhanced considerably by a reduction in the overall census of CDCR. Determining the level of reduction needed to achieve equilibrium between the need for and an adequate supply of services, however, is no easier to calculate than the precise extent of the existing disequilibrium.

The impact of a reduction of population on staffing seems easy to discern. If the percentage of the caseload census in the overall population is a predictable 19 to 20 percent, the ratio of clinicians to inmate/patients should improve directly in proportion to the decline in overall population and begin swiftly to ameliorate the impact of high vacancy rates among clinicians. An estimate based on the current overall ratio of staff to caseload (roughly one clinician for 23 caseload inmate/patients) might suggest that a reduction of approximately 9,500 caseload inmate/patients (29 percent of the MHSDS caseload) would lead to an acceptable staff ratio (roughly one clinician for 16 caseload inmate/patients).

[15] Reduction of the caseload by 9,500 inmate/patients would require an overall population drop of 50,000 inmates, but even such a decline in the overall population would probably not raise staffing resources into equilibrium with the mental health caseload. Clinicians cannot be spread out evenly like butter over the MHSDS caseload. Staffing ratios are much more intensive in MHCB units, PSUs, EOPs, administrative segregation units and reception centers than they are in general population 3CMS programs. Some 425 of CDCR's 1,002.38 allocated case mangers serve the 28,154 3CMS inmate/patients in general population and administrative segregation, while the remaining 575 attend to the treatment needs of the some 4,600 inmate/patients in MHCB units, PSUs and EOPs. Thus, the impact of a population cut on mental health staffing depends more on the nature of the program cut than the overall numbers of inmates diverted. Even the release of 100,000 inmates would likely leave the defendants with a largely unmitigated need to provide intensive mental health services to program populations that would remain undiminished by a reduction of some 19,000 3CMS inmates. This would suffice to cover just the functional vacancy rate among case managers. Only a targeted release of seriously mentally ill inmates will serve quickly to reverse current deficiencies, especially of bed and program space. Still, the most seriously mentally ill inmate/patients in CDCR are

unlikely to be among those released pursuant to any of the provisions of defendants' Assembly Bill 900.

With few exceptions, much the same analysis is applicable to defendants' need for beds and programming space at the most intensive levels of mental health treatment. Problems related to programming space may seem more amenable to amelioration, but remember that none of CDCR's institutions was designed to provide [16] any treatment space for mental health inmate/patients. The need for beds and programming space, again, are most imperative for those most desperately mentally ill caseload inmate/ patients, few of whom will be likely candidates for release under the defendants' plans or a court-ordered cap. Even draconian population reductions will have only limited impact on these inmate/ patients currently suffering most egregiously from restricted access to needed mental health treatment. Unhappily, there is no clear answer to the inquiry about the level of overall population reduction will allow the provision of constitutionally adequate care to all members of the plaintiff class.

V. *Conclusion*

The impact of any reduction in the overall inmate population on the delivery of mental health services will also depend on a number of factors not addressed here, including the effective organization and competency of CDCR's custody, healthcare, mental health and overall management; the stability, quality and morale of mental health staff; and the ability of the executive and legislative branches of state government to sustain over the long haul the plethora of reform measures adopted in the present crisis. Many of these issues have been addressed in the submissions on overcrowding submitted in *Plata* and the voluminous pleadings of parties in *Coleman*.

Each of the disparate elements of healthcare currently the subject of various pending federal court intervention, including medical, dental and mental health services and the application of the Americans with Disabilities Act, has had its own unique history and development. As one of the earliest of this quartet of cases to be decided and launched on its remedial quest, *Coleman* has the richest history of waxing and waning accomplishments. Over the past 11-plus years, much has been achieved, and [17] many of the achievements have succumbed to the inexorably rising tide of population, leaving behind growing frustration and despair. While this report certainly strikes no optimistic or encouraging note, it is a useful reminder that there is no judicial *deus ex machina* that will free the Court, the special master, the receiver, the parties or counsel from the continuing and perhaps interminable struggle ahead to drag CDCR into constitutional compliance until the State of California re-thinks the place of incarceration in its criminal justice system.

Respectfully submitted,

/s/ J. Michael Keating, Jr.
J. Michael Keating, Jr.
Special Master

May 31, 2007

[1] ORDER DESIGNATING UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. CIV S-90-0520 LKK JFM P
Eastern District of California

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
Northern District of California

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Pursuant to 18 U.S.C. §3626(a)(3) the Honorable Lawrence K. Karlton, Senior District Judge for the Eastern District of California and the Honorable Thelton E. Henderson, Senior District Judge for the Northern District of California have each requested the appointment of a single three-judge district court pursuant to 28 U.S.C. §2284 to consider the above-captioned matters.

[2] Having received this statutory notification, I grant the requests and hereby designate and appoint the Honorable Stephen Reinhardt, United States Circuit Judge for the Ninth Circuit, to sit with the Honorable Lawrence K. Karlton and the Honorable Thelton E. Henderson to hear and determine the above-captioned causes as, respectively, the district court for the Eastern District of California and as the district court for the Northern District of California, at a time and place and in a manner to be agreed upon by the court.

Date: July 26, 2007

/s/ Mary M. Schroeder
Mary M. Schroeder
Chief Judge
United States Courts for the Ninth Circuit

cc: Circuit Judge Stephen Reinhardt
Senior District Judge Thelton E. Henderson
Senior District Judge Lawrence K. Karlton
Chief District Judge Vaughn R. Walker
Chief District Judge Garland Burrell
Cathy Catterson, Clerk, Court of Appeals
Richard Wieking, Clerk, Northern District of California
Victoria Minor, Clerk, Eastern District of California

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. Civ S 90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

EXPERT REPORT OF PROFESSOR CRAIG HANEY

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[1] I. INTRODUCTION

1. I am a Professor of Psychology and former Chair of the Department of Psychology at the University of California at Santa Cruz. I have been teaching graduate and undergraduate courses in social psychology, research methodology, psychology and law, forensic psychology, and institutional analysis at the University of California for 30 years, and previously served as the Director of the Graduate Program in Psychology, Chair of the Legal Studies Program, and Chair of the Department of Sociology. I received a Ph.D. in Social Psychology from Stanford University and a J.D. degree from the Stanford Law School. I have been the recipient of a number of scholarship, fellowship, and other academic awards and have published approximately one hundred scholarly articles and book chapters on topics in law and psychology, including encyclopedia and handbook chapters on conditions of confinement and the psychological effects of incarceration. My book on the psychological consequences of imprisonment, *Reforming Punishment: Psychological Limits to the Pains of Imprisonment*,[1] was published by the American Psychological Association in 2006. (My curriculum vitae is attached to this Report as "Appendix A.")

2. For approximately 35 years, I have been studying the psychological effects of living and working in institutional environments. In the course of that work, I have conducted what is perhaps the only laboratory experiment ever done on the acute psychological effects of prison-like environments.[2]

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[1] *Craig Haney, Reforming Punishment: Psychological Limits to the Pains of Imprisonment*. Washington, DC: APA Books (2006).

[2] This study was originally published as Haney, C., Banks, C., and Zimbardo, P., Interpersonal Dynamics in a Simulated

This research, which has come to be known as the "Stanford Prison [2] Experiment," is regarded as a classic social psychological study of the effects of institutional environments.[3] For the 35 years since that study was completed, I have continued to study and publish scholarly articles on the psychology of imprisonment. That research has included conducting numerous interviews with correctional officials, officers, and prisoners to assess the nature and consequences of living and working in correctional

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Prison, 1 *International Journal of Criminology and Penology* 69 (1973), and has been reprinted in numerous books in psychology and law and translated into several languages. For example: Steffensmeier, D., and Terry R. (Eds.) *Examining Deviance Experimentally*. New York: Alfred Publishing, 1975; Golden, P. (Ed.) *The Research Experience*. Itasca, Ill.: Peacock, 1976; Leger, R. (Ed.) *The Sociology of Corrections*. New York: John Wiley, 1977; *A kiserleti tarsadalom-lelektan foarma*. Budapest, Hungary: Gondolat Konyvkiado, 1977; Johnston, N., and Savitz, L. *Justice and Corrections*. New York: John Wiley, 1978; *Research Methods in Education and Social Sciences*. The Open University, 1979; Goldstein, J. (Ed.), *Modern Sociology*. British Columbia: Open Learning Institute, 1980; Ross, R. (Ed.) *Prison Guard/ Correctional Officer: The Use and Abuse of Human Resources of Prison*. Toronto: Butterworth's 1981; Monahan, J., and Walker, L. (Eds.), *Social Science in Law: Cases, Materials, and Problems*. Foundation Press, 1985; Siuta, Jerzy (Ed.), *The Context of Human Behavior*. Jagiellonian University Press, 2001; and Ferguson, Susan (Ed.), *Mapping the Social Landscape: Readings in Sociology*. St. Enumclaw, WA: Mayfield Publishing, 2001; Pethes, Nicolas (Ed.), *Menschenversuche (Experiments with Humans)*. Frankfurt, Germany: Suhrkamp Verlag, 2006.

[3] The American Psychological Association sponsored a "retrospective" commemorating the 25th anniversary of this study at its Annual Convention a decade ago. *See, also*, Haney, C., and Zimbardo, P., The Past of Future of U.S. Prison Policy: Twenty-Five Years After the Stanford Prison Experiment, 53 *American Psychologist* 709-727 (1998).

settings. In addition, I have statistically analyzed aggregate correctional data to examine the effects of overcrowding, punitive segregation, and other conditions of confinement on the quality of prison life and the ability of prisoners to adjust to them.

3. In addition, I have toured and inspected and analyzed conditions of confinement at numerous state prisons (including in Alabama, Arkansas, Arizona, California, Florida, Georgia, Idaho, Louisiana, Massachusetts, Montana, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, Texas, Utah, Washington, and Wyoming), maximum security federal prisons (at McNeil Island, Washington, Marion, Illinois, and the Administrative Maximum or "ADX" facility in Florence, Colorado), as well as prisons in Canada, Cuba, England, Hungary, and Russia. In 1989, I received a UC-Mexus grant to conduct a comparative study of prisons and prison policy in the United States and Mexico. As a result of that research grant, I toured a number of Mexican prisons, interviewed correctional officials and, in conjunction with United States Department of State officials, interviewed many United States citizens who were incarcerated in Mexico.

[3] 4. I have lectured and given invited addresses throughout the country on the psychological effects of living and working in institutional settings (especially maximum security prisons) at various law schools, bar associations, university campuses, and numerous professional psychology organizations such as the American Psychological Association. I have also served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations, including the Palo Alto Police Department, the California Judicial Council, various

California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the NAACP Legal Defense Fund, and the United States Department of Justice.

5. For example, in the summer of 2000, I was invited to attend and participated in a White House Forum on the uses of science and technology to improve crime and prison policy, and in 2001, I participated in a conference jointly sponsored by the United States Department of Health and Human Services (DHHS) and the Urban Institute concerning government policies and programs that could better address the needs of formerly incarcerated persons to facilitate their reintegration into their home communities. I continued to work with DHHS and other organizations on the issue of how best to maximize the success of recently released prisoners. And, in 2005, I was the Scholar-in-Residence at the Center for Social Justice, at the Boalt Hall School of Law, a role that included delivering an invited lecture at the school on the psychological effects of conditions of confinement and consulting with law students and faculty members on a variety of prison-related issues.

6. In addition to the research I have conducted into the psychological effects of confinement and patterns of adjustment in institutional settings, I also have extensive experience evaluating the life histories and psychological reactions of individual clients in the criminal justice system. Beginning as a Law and Psychology Fellow at the Stanford Law School in the mid-1970s, I participated for several years in an intensive clinically-oriented course co-taught by law professor Anthony Amsterdam and psychiatrist Donald Lunde that sensitized me to the special

problems and vulnerabilities of psychiatrically-impaired criminal defendants and prisoners with special needs. Since that time I have been extensively involved [4] in teaching and conducting research on a variety of forensic issues that have placed me in continuing contact with diverse prisoner populations, many of whose members suffer from adverse effects of institutionalization, as well as pre-existing psychiatric disorders and developmental disabilities.[4]

7. For example, over the last 25 years I also have been studying the backgrounds and social histories of persons accused and convicted of violent crime. In the course of this research, I have evaluated the background and social histories of defendants and convicted persons, carefully assessed the effects of prior periods of institutionalization, and analyzed the ways in which these factors have influenced the development and psychological functioning of the persons in question. Much of that work has entailed an assessment of the potentially adverse effects of their institutional histories as well as evaluations of their potential for future prison adjustment.

8. My interests in these broad issues within the general area of psychology and law is both academic and professional. Thus, in the course of my work on conditions of confinement, adjustment to incarceration, and effects of institutionalization on persons accused or convicted of violent crime, I have been qualified and have testified as an expert in various state and federal courts, including the Superior

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[4] For example, *see* Haney, C., and Specter, D., Legal Considerations in the Treatment of "Special Needs" Offenders, in Ashford, J., Sales, B., and Reid, W., (Eds.), *Treating Adult and Juvenile Offenders with Special Needs* (pp. 51-79). Washington, D.C.: American Psychological Association (2000).

Courts of Lake, Los Angeles, Marin, Monterey, Orange, Sacramento, San Diego, San Francisco, and Ventura counties in California, state courts in New Jersey, New Mexico, Oregon, Wyoming, and Utah, as well as Federal District Courts in the Western and Eastern Districts of Washington, the Northern, Southern, and Eastern Districts of California, the District Court of New Mexico, and the Southern District of Illinois.

9. In the course of this academic and professional work, I have also evaluated and testified concerning the psychological effects of conditions of confinement in the mainline [5] housing units of various maximum and medium security prisons in a number of states (including California, New Jersey, New Mexico, Oregon, Utah, and Washington). For example, I have evaluated and provided testimony about the psychological effects of overcrowded conditions of confinement in the mainline housing units at the California Men's Colony, Folsom, San Quentin, and Soledad prisons. In the mid-1980s I toured, inspected and conducted extensive interviews in more than a half dozen Texas prisons, and examined and analyzed numerous documents as the basis for an opinion about the psychological effects of overcrowding in the Texas Department of Corrections.

10. I have often focused in this work on the effects of conditions of confinement on so-called "special needs" prisoners (primarily the mentally ill and developmentally disabled). For example, under the auspices of the United States Department of Justice, I evaluated conditions of confinement and the quality of care provided at Atascadero State Hospital, a forensic facility designed to house mentally-ill and developmentally-disabled offenders for the State of California. Also, as noted above, I testified as an

expert witness concerning conditions of confinement and their effects on prisoners at the California Men's Colony, which was a treatment-oriented facility in which many mentally-ill prisoners were housed at the time I evaluated it. In addition, I evaluated the effects of conditions of confinement on prisoners at the California Medical Facility at Vacaville (including prisoners housed in the Department of Mental Health units), [5] and also testified about the prevalence of seriously mentally-ill prisoners in the California Department of Corrections, as well as the special psychological problems that living in isolated housing units created for them. [6] I have also evaluated the psychological effects of conditions of confinement at juvenile justice facilities, on the condemned or "death [6] row" units in several states (including Arkansas, California, New Mexico, and Texas), and in various special treatment facilities for sex offenders (in Florida and Washington).

11. In much of my research, writing, and testimony about prison conditions, especially in recent years, I also have focused on the assessment of the psychological effects of confinement in so-called "lockup," punitive segregation, or so-called "supermax" confinement (in what are variously known as management control, security housing, high security, or close management units).[7] This has included tours and

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[5] *Gates v. Deukmejian*, Civ-S-87-1636 LKK-JFM (E.D. Cal.) (1990).

[6] *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

[7] *See, generally*, Haney. C., and Lynch, M., Regulating Prisons of the Future: The Psychological Consequences of Supermax and Solitary Confinement, 23 *New York University Review of Law and Social Change* 477-570 (1997); and Haney, C., Mental Health Issues in Long-Term Solitary and "Supermax"

inspections and interviews in a number of what were once called "management control units" as well as "security housing units" in institutions in California, in several separate prisons or specialized units in each of the states of Louisiana, Massachusetts, New Mexico, Oregon, Texas, and Washington, as well as at the Federal Penitentiary at Marion, Illinois. For example, I have testified about the effects of isolation and social deprivation in the Security Housing Unit at Pelican Bay State Prison,[8] and in several of the High Security Units in the Texas Department of Corrections.[9]

II FOUNDATION FOR EXPERT OPINIONS IN THIS ACTION

12. I was retained by attorneys for Plaintiffs in *Coleman v. Schwarzenegger* and *Plata v. Schwarzenegger* to complete several inter-related tasks. Those tasks included reviewing and summarizing the existing psychological and social science literature on the effects of overcrowding in prison settings. They also included reviewing an extensive number of documents provided by Plaintiffs' counsel that pertain to the current nature and quality of medical and mental health care in the California Department of Corrections and Rehabilitation (CDCR), the conditions of confinement that prevail throughout the state's prison system and, [7] especially, the ways in which these things may be affected by the chronic and severe overcrowding that continues to plague

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Confinement, *Crime & Delinquency* (special issue on mental health and the criminal justice system), *49*, 124-156 (2003).

[8] *See, Madrid v. Gomez*, 889 F. Supp. 1146, 1280 (N.D. Cal. 1995).

[9] *See, Ruiz v. Johnson*, 37 F. Supp. 855 (S.D. Texas 1999).

CDCR facilities. An updated list of the documents I was provided by Plaintiffs' counsel and reviewed in advance of preparing this report is appended as Appendix B. A list of prior cases in which I have testified at trial or deposition in the past four years and a statement of compensation is attached as Appendix C. I submit the present report to update and replace my report dated November 9, 2007.

13. In addition to the documents reviewed, as listed in Appendix B, I also conducted tours and interviews in numerous housing units located in eight prisons where *Coleman* class members reside.[10] The prisons were: California Institution for Men (CIM), in Chino, California; Valley State Prison for Women (VSPW), in Chowchilla, California; Salinas Valley State Prison (SVSP), in Soledad, California; Mule Creek State Prison (MCSP), in Ione, California; California Substance Abuse and Treatment Facility (SATF), in Corcoran, California; California Correctional Institution (CCI), in Tehachapi, California; North Kern State Prison (NKSP), in Delano, California; and Wasco State Prison (Wasco), in Wasco, California. In the course of these tours, I made a point of visiting a representative sample of mainline housing units, including those that had been impacted by the severe overcrowding in CDCR (e.g., housing units that had been converted into makeshift dayroom and gymnasium dormitories). I also toured areas that contained specialized mental health and crisis beds. Because of the special sensitivity and vulnerability of mentally ill prisoners to the harsh regimes that exist in

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[10] *Coleman* class members are CDCR prisoners with serious mental illness.

Administrative Segregation Units (ASUs),[11] I also made a point of touring and speaking to a number of the mentally ill prisoners housed in the ASUs at each of the prisons. In the cases of VSPW and CCI, I also toured and spoke to men and women housed in [8] the Security Housing Units (SHU),[12] where prisoners also are housed under severe locked down conditions. In addition, in the course of touring the last four CDCR facilities that I visited, we photographed a number of different areas inside the prisons themselves. I have reviewed and relied on those photographs, as well as photographs and videos materials obtained from the CDCR's own publicly accessible website depicting conditions inside CDCR institutions.

14. In addition to the tours themselves, and my conversations with correctional administrators, clinical staff, and line correctional officers, I was able to converse with numerous prisoners who were participants in the CDCR's mental health delivery system, including many who were in the Correctional

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[11] Administrative Segregation Units are locked-down units within the prison where prisoners are housed for a wide variety of "administrative" reasons. Special security procedures are used in the transport of Ad Seg prisoners and their out-of-cell time and other program participation is drastically reduced. They spend the overwhelming majority of their time locked in their cells.

[12] Security or Secured Housing Units are also locked-down units within the prison where prisoners are housed as a result of disciplinary infractions (specific offenses committed in prison, or gang status), or sometimes for safety-related concerns. As with AD SEG prisoners, special security procedures are used in the transport of SHU prisoners and their out-of-cell time and other program participation is drastically reduced. They, too, spend the overwhelming majority of their time locked in their cells.

Clinical Case Management System (CCCMS)[13] as well as those in the Enhanced Outpatient Program (EOP).[14] I also conducted private, one-on-one interviews with individual prisoners who were selected by Plaintiffs' counsel from the various lists of CCCMS and EOP prisoners at each facility and from correspondence.

[9] 15. Finally, I was asked to formulate expert opinions concerning: a) the impact of overcrowding on prisons, prison systems in general, and the California prison system in particular; b) whether and how overcrowding is the primary cause of the continuing constitutional violations that have been identified in the California prison system; c) whether and why a prisoner relief order is the only appropriate remedy to the overcrowding-related constitutional violations that continue to plague the California prison system; and d) assuming that the Court will issue a prisoner release order, what population level or percentage of

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[13] CCCMS prisoners constitute the largest CDCR mental health category. It comprises some 28,000 prisoners with mental illness who live in general population housing, and are supposed to receive medication management and meet with their case manager every 90 days. When CCCMS prisoners are housed in Ad Seg, they are supposed to receive enhanced mental health services that include weekly case manager contact and daily rounding from psychiatric technicians.

[14] EOP includes seriously mentally ill prisoners who require a higher and more intensive level of mental health care. These prisoners are unable to function in a general population prison setting and, as a result, are supposed to be in sheltered treatment programs and live in segregated housing units. They are supposed to receive 10 hours each week of therapy or "structured therapeutic activities." When they are housed in Ad Seg, they are supposed to be provided with weekly case manager contact and receive daily rounding from psychiatric technicians. There are approximately 4,900 EOP prisoners in the CDCR.

design capacity is an appropriate target that is likely to remedy the overcrowding-related constitutional violations.

III. EXPERT OPINIONS

A. Summary of Expert Opinion

16. The relevant psychological and social scientific literature on prison overcrowding underscores its negative impact on virtually every aspect of prison life, from the pains of imprisonment suffered by prisoners, to the performance and well-being of correctional officers and other prison employees, to the way in which individual institutions and prison systems discharge their constitutionally mandated duties and functions. In my experience as a scholar and researcher who has studied prisons in the United States for more than 35 years, no other single aspect or condition of confinement has had a more significant impact on the prisons of this country or prisons in the State of California.

17. Because of the tremendous importance of overcrowding and its impact on virtually every aspect of prison life, it is my opinion that it is the primary cause of the continuing constitutional violations that plague the California prison system, including the CDCR's inability to provide medical and mental health care for state prisoners that meets the relevant constitutional minimum standards.

18. It is my opinion that a prisoner release order that results in a significant and expeditious reduction in the number of prisoners housed in the CDCR is the only appropriate remedy to the continuing overcrowding-related constitutional violations. I base this opinion on my knowledge of and experience with court-ordered institutional change in this state and

[10] others, as well as my knowledge of the depth and magnitude of the overcrowding problem in the CDCR—a problem that reached crisis-level proportions many years ago and has been allowed to continue to worsen. I also base this opinion on my knowledge of the history of prison overcrowding in California and the CDCR's decades-long record of failing to anticipate the magnitude of this problem, failing to recognize the urgency of the continuing overcrowding crisis it faced, and failing to fully appreciate the harm inflicted on prisoners, staff members, and California communities by levels of prison overcrowding it came to regard as "acceptable" or "tolerable." The gap between the urgency of the problem and the insufficiency of CDCR's response is evident in their projected "best case scenario" date for a solution—the year 2014—which underscores why a prisoner release order is necessary. Even the active involvement of the *Plata* Receiver in addressing the shortfall of mental health beds in the system will not appreciably advance this date. Thus, although it is my understanding Receiver does not intend to build all of the outstanding mental health beds that will be required by the CDCR, the construction of the new mental health/medical facilities that the Receiver does plan to build are projected to be completed in July 2013. [15] However, even the Receiver has acknowledged that there is uncertainty of this completion date. Thus, he has said "[t]he key to hitting our 2013 target date for completing this objective is the commencement of construction at the

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[15] Joint Pls.' Trial Ex. 56 at Exhibit 1 at 28; Coleman Pls.' Trial Ex. 55 at 7 showing the following mental health bed projects to be constructed by CDCR: 50 bed MHCB at CMC, 32-bed MHCB at SQ, and 67 EOP bed at CMF.

first site no later than February 2009, with construction completed at that site no later than February 2011."[16]

1. Nature of the Continuing Constitutional Violations

19. In its July 23, 2007 Order referring consideration of a prisoner release order to the three-judge panel, the *Coleman* Court concluded that CDCR's mental health care delivery system has not come into compliance with the Eighth Amendment, despite twelve years of [11] remedial work in this case.[17] The Court cited significant delays in access to care at the highest levels of need, alarming rates of staffing vacancies, and a severe lack of programming space, among other problems, as evidence that the current level of *unmet* mental health need in the CDCR—estimated by the *Coleman* Special Master to be one-third of the *Coleman* class—"is unconscionable."[18] The Court noted that although it has issued at least seventy-seven orders over more than eleven years directed at bringing California's prison mental health care system into constitutional compliance, "the system still falls woefully short of meeting the requirements of the Eighth Amendment."[19]

20. The *Coleman* Special Master, in a Report filed with the Court on May 31, 2007 regarding the effects of overcrowding on mental health treatment, concluded that a lack of treatment and programming space, beds, and staff was still pervasive throughout

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[16] *Id.*

[17] Coleman Pls.' Trial Ex. 46 at 6:6-8.

[18] Coleman Pls.' Trial Ex. 46 at 6-7.

[19] Coleman Pls.' Trial Ex. 46 at 8:4-10.

the CDCR system. He provided a number of examples, including a consistent *decline* over the past two years "in the number of hours of therapeutic activities offered in most institutions to Enhanced Outpatient Program prisoner/patients in administrative segregation units, repeatedly attributed to the acute absence of adequate space." [20] The Special Master also reported a functional vacancy rate among clinicians of 19.86 percent, and concluded that there was sufficient staff to provide full mental health services to roughly two-thirds of the mental health caseload.[21] He noted that this analysis "does not even address the endemic shortages of escort correctional officers, nursing staff, clerical and records keeping personnel, pharmacy staff and lab technicians."[22]

[12] 21. Some of the standards for measuring whether constitutional requirements are being met are set forth in the Revised Program Guide approved by the *Coleman* Court ("Program Guide"). On March 2, 2006, the *Coleman* Court ordered defendants to immediately implement the Program Guide, which provides the protocol for the provision of mental health care in the CDCR. [23] I have reviewed the standards in the Program Guide relevant to this declaration.

22. One of the key elements of the Program Guide is the transfer timeline chart that sets forth the required timeframes for transferring prisoners to appropriate levels of care.[24] For obvious reasons, the

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[20] Joint Pls.' Trial Ex. 35 at 6.

[21] *Id.* at 11-12.

[22] Joint Pls.' Trial Ex. 35 at 12.

[23] Coleman Pls.' Trial Ex. 47.

[24] Joint Pls.' Trial Ex. 9 at 12-1-13.

ability of a mental health delivery system to meet these timeframes is indispensable to the provision of adequate mental health care. They are, in essence, the limits placed on the amount of time a prisoner/patient must wait before receiving the care that clinicians have determined he or she needs. In relevant part, these timeframes are:

> Reception Centers: EOP transfers should occur within 60 days, or 30 days if clinically indicated. CCCMS transfers should occur within 90 days, or 60 days if clinically indicated.
>
> MHCB: MHCB transfers should occur within 24 hours of referral.
>
> DMH: Transfers to DMH acute placements should occur within 10 days of referral, if accepted to DMH. Referral must be completed within 2 working days of identification. Transfers to DMH intermediate care placements should occur within 30 days of referral, if accepted to DMH. Referral must be completed within 5-10 working days.
>
> [13] EOP: Transfers to general population ("GP") EOP programs should occur within 60 days, or 30 days if clinically indicated.
>
> EOP Administrative Segregation Unit ("ASU") Hub: EOP prisoners housed in the regular ASU should transfer to an EOP ASU Hub within 30 days of placement in the regular ASU or within 30 days of referral to EOP level of care.
>
> PSU: EOP prisoners housed in the ASU who are endorsed for the PSU must be transferred within 60 days of endorsement.

23. In the Court's July 23, 2007 Order referring this matter to the three-judge panel, the Court found, based upon information documented by the Special Master, that these transfer timelines are not being met.[25] The Special Master reported that "[d]elays in transfers, especially to the most intensive treatment programs for prisoners at the highest custody levels [have become] "endemic."[26]

24. Housing at the appropriate level of care, the ability to transfer prisoner-patients to appropriate levels of care, and the resources to provide treatment at each level of care are key elements in the provision of mental health care. The State does not have enough beds at nearly every level of care right now (Fiscal Year 2007/2008).[27]

25. Additionally, the *Coleman* Special Master recently reported in his Report and Recommendations on Defendants' August 2007 Supplemental Bed Plan that "[f]inding available beds in either of these programs [MHCB and inpatient DMH] remains a daily challenge that still exceeds CDCR's capability . . ."[28] In June 2007, the Court found that [14] "Defendants are providing to class members only twenty-six percent of the beds at ASH [DMH inpatient psychiatric program] called for by their plan. That is unacceptable."[29] The Special Master also concluded that recent events, including the population crisis, implementation of the *Plata* Receivership, and defendants' new-

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[25] Coleman Pls.' Trial Ex. 46 at 6.

[26] *Id.*

[27] *See, generally*, Coleman Pls.' Trial Ex. 12.

[28] Coleman Pls.' Trial Ex. 12 at 3.

[29] Coleman Pls.' Trial Ex. 8 at 3:4-5.

est bed plan, "have caused widespread confusion and uncertainty, which now threaten to stall the allocation of construction and operational funding critically needed to meet the increasingly desperate need for acute and intermediate inpatient and mental health crisis beds in CDCR."[30] In May 2006, the Court described the effect of the shortage of intermediate care facility beds and mental health crisis beds in the CDCR: "It is undisputed that the shortage is leaving critically mentally ill prisoners languishing in horrific conditions without access to immediately necessary mental health care."[31] Even in his 15th Report, the Special Master warned that the long waiting lists for the special MHCB, PSU, and DMH beds meant that "suicidal and other seriously mentally ill and violent inmates lack access to clinically necessary levels of monitoring and treatment."[32] In a Report issued in the summer of 2008, the *Coleman* Special Master found that the shortage of MHCBs remained a barrier to clinically adequate care. Specifically: "[t]imely access to appropriate levels of care, essential to the efficacy of a mental health delivery service continued to elude CDCR."[33] In addition, the Special Master documented the continued use of alternative sites for prisoners who required MHCB level of care, a practice that was a direct result of the MHCB shortages. Moreover, he described these sites as "uniformly inappropriate for acute care."[34] In fact, as the Special Master noted, "[f]ourteen institutions that did not have adequate access to licensed crisis beds [15] resorted to using a variety of temporary monitoring arrangements, most of which were grossly inappropriate alternatives to acute care." [35]

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[30] Coleman Pls.' Trial Ex. 5 at 9-10.

[31] Coleman Pls.' Trial Ex. 3 at 2:16-18.

[32] Joint Pls.' Trial Ex. 40 at 421.

[33] Joint Pls.' Trial Ex. 57 at 349.

[34] *Id.* at 352.

26. In the Special Master's most recent draft report on suicides within the CDCR, he found that "[c]ontinuing use of ZZ cells and other holding cells for inmates awaiting transfers to *bonafide* CTCs with MHCBs, and placements in OHUs that exceeded the 72-hour time limitations, were ongoing obstacles to the care of inmates in need of constant or close monitoring or timely transfer to higher levels of care.[36]

27. The documents that I reviewed clearly indicate that, as I noted earlier, defendants do not anticipate being able to meet the need for mental health beds at every level of care until 2014, at best. For example, the Coleman Special Master concluded in his Report filed September 24, 2007 that full implementation of defendants' latest proposed bed plan "will stretch out" to January 2014.[37] He also noted that "objections to defendants' present and preceding bed plans on the part of plaintiffs, experts, special master and the Court all reflect a decade of accumulated experience and frustration that justifies fully concerns about CDCR's ability to generate and implement this latest plan effectively."[38] The Special Master further suggested that the actual implementation of the defendants' bed plan may be unlikely to occur within a decade.[39]

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[35] *Id.*

[36] Joint Pls.' Trial Ex. 58 at 11.

[37] Coleman Pls.' Trial Ex. 12 at 11.

[38] *Id.* at 12.

[39] *Id.* at 13.

28. Similarly, the Receiver has acknowledged the many serious obstacles he has faced in his efforts to construct adequate health care facilities, which will include mental health beds.[40] In his most recent quarterly report to the *Plata* Court, the Receiver stated: "before [16] constitutionally adequate health care can be delivered in California's prisons, there needs to be *constitutionally adequate treatment facilities to provide such care*. Unless and until these facilities are constructed, the major health care class action cases will continue indefinitely. Likewise, prisoners will continue to die unnecessarily." [41] Nevertheless, despite "avoidable prisoner deaths" that "illustrate the human cost of the State's failure to provide adequate funding for needed health care treatment facilities," the Receiver concluded that the "State's failure to make this necessary financial commitment puts the Receiver's entire remedial program at risk."[42] A significant part of the Coleman mental health bed plan may be folded into the Receiver's plan to construct medical and mental health treatment facilities for 10,000 prisoner-patients.[43]

29. Meanwhile, some of the beds that CDCR is routinely operating at higher levels of care are, in fact, overflow "jury-rigged" or makeshift units that do not meet appropriate standards for mental health treatment, according to CDCR and DMH guidelines. One example of this is occurring in the Reception Center EOP Program. This program appears to be a

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[40] Joint Pls.' Trial Ex. 56 at 46-47.

[41] *Id.*

[42] *Id.* at 56.

[43] Coleman Pls.' Trial Ex. 55.

"stopgap" response to the overwhelming population pressures in CDCR. EOP patients are not being transferred out of Reception Centers in a timely manner, and some serve their entire terms there. However, the guideline for the Reception Center EOP Program approved as an emergency stopgap by the Court is not equal to the care mandated by the Program Guide for EOP patients. For example, the Reception Center EOP program provides for only five hours of treatment per week, while EOPs housed in mainline EOP or EOP administrative segregation programs must be provided with a minimum of ten hours of treatment per week.[44] Furthermore, due to overcrowding within CDCR, Reception Center EOPs were not [17] congregated in designated housing units despite the fact that EOP program is "characterized by a separate housing unit . . . for mentally ill inmate-patients who, because of their illness, experience adjustment difficulties in a General Population (GP) setting."[45] Yet, in July 2007, the *Coleman* Special Master reported to the Court that this is the level care that is and will be provided to a significant number of prisoners who require an EOP level of care: "Apart from EOP prisoners in administrative segregation, mental health crisis beds, or alternative housing pending admission to mental health crisis beds, on May 25, 2007, there were 463 EOP inmates in the seven reception centers surveyed in this report, representing over ten percent of all EOP inmates in CDCR institutions."[46] The number of such prisoners continues to grow. Thus, by June 2008, the number of EOP patients housed in the same seven reception centers had reached 707—all patients waiting transfer to a mainline EOP program.[47] An additional 79 EOP patients were housed in other reception centers around the CDCR.[48] In addition, however, as I learned in my most recent tours and will detail below, even these "reduced" level of care Reception Center EOP programs are makeshift programs operated out of makeshift spaces under circumstances and staffing levels that compromise the quality of care provided.

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[44] Coleman Pls.' Trial Ex. 9.

[45] Joint Pls' Trial Ex. 9 at 12-4-1.

[46] Coleman Pls.' Trial Ex. 9 at 28.

30. Similarly, some of the units currently operating as intermediate care facilities at SVPP and CMF do not meet the criteria for DMH intermediate care facilities. The D-5 and D-6 units at SVPP and the P-2 and P-3 units at CMF are operating as "interim" intermediate care programs, and the Court waived the state licensing requirements for inpatient facilities so that defendants could meet this overflow need in the short term, given the current emergency the [18] CDCR faces.[49] However, these units do not have the appropriate treatment space for mental health patients at this level of acuity, nor do they have the resources to provide yard and out-of-cell time in the appropriate manner. For example, in the SVPP D-5 and D-6 units, all mental health treatment occurs on the dayroom floor. On October 18, 2007, the Court ordered defendants to develop and submit proposals for developing "adequate mental health treatment and counseling space" at these SVSP and CMF units.[50] Defendants have created construction

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[47] Coleman Pls.' Trial Ex. 57: CIM, 196, DVI 70, NKSP 69, RJD 96, LAC 113, SQ 45, WSP 118.

[48] *Id.*

[49] Coleman Pls.' Trial Ex. 3 at 4-5.

[50] Coleman Pls.' Trial Ex. 48 at 6.

proposals for SVSP and CMF in response to the October 2007 Coleman order,[51] but these are long-term projects that, under the best case scenario, will take years to complete. Thus, the SVSP proposal includes treatment space for both the EOP and the DMH units, but has a projected completion date of January 2011 that is contingent on being funded by the Legislature.[52] The CMF treatment space proposal covers only the EOP program, but it projects a completion date of 2012, and only if funding is approved.[53] In the meantime—a period of several years at best—the existing mental health treatment programs will be forced to "make do" with the existing inadequate treatment space.

31. The tours that I have completed, discussions I have had with numerous mental health and custody staff, and the extensive documents I have reviewed all confirm that institutions throughout the California prison system are using a variety of different types of "overflow" housing to scramble to meet their pressing need for MHCB beds. These include housing such as OHU beds, "Mental Health" OHU ("MOHU") beds, and "ZZ" cells. In his May 31, 2007 Report to the Court, the *Coleman* Special Master found that: "Over the past three years, however, the number of inmate/patients referred to a MHCB level of care has [19] regularly and significantly exceeded the number of MHCBs available in CDCR, resulting in the placement of inmate/patients in need of a MHCB level of care in a variety of temporary housing alternatives, which often lack the heightened monitoring

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[51] Coleman Pls.' Trial Exs. 58-59.

[52] *Id.*

[53] *Id.*

and treatment essential to the MHCB level of care . . . . Most of these alternative placements lack suitable staffing and/or the physical configuration needed for the continuous monitoring or intensive treatment provided in a MHCB unit. While strict time limits on their use are prescribed in both department and local policies, they are not consistently observed."[54] The problem persists. Thus, the continued use of alternative sites to house prisoner requiring MHCB placement was documented overall by the Special Master in his draft 20th Report and by individual institutions during the 21st round monitoring tours.[55]

32. The situation at the California Men's Colony (CMC) provides just one illustrative example of the chronic nature of this problem. In 2006, the *Coleman* Court ordered that a locked observation unit (LOU) at CMC be re-opened despite its failure to meet state law licensing requirements. The Court found that although "State licensing requirements serve an important function . . . It is essential to provide immediately mental health crisis beds to critically ill inmates in the CDCR . . . Under present circumstances, state licensing requirements must temporarily give way to measures necessary to remedy the Eighth Amendment violations that remain unresolved in this action."[56] The unlicensed facility at CMC provides crisis bed care at a prison that has a large mental health population, including more than 500 EOP

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[54] Joint Pls.' Trial Ex. 35 at 3-4.

[55] Joint Pls.' Trial Ex. 57 at 352; and *see, e.g.* Coleman Pls.' Trial Exs. 60-61: CIM Memo May 7, 2008 re activation of TBH in March and April 2008; DVI SPR-FIT, 4/9/08, L-Wing overflow Unit population was 89; DVI SPR-FIT, 5/14/08, L-Wing overflow unit population was 84.

[56] Coleman Pls.' Trial Ex. 3 at 3-4.

patients.[57] On March 27, 2007, the Coleman court ordered defendants to complete and occupy a 50 bed [20] MHCB at CMC "as soon as possible." However, this project remains stalled. On February 26, 2008, the *Coleman* court, in an order regarding the construction agreement in *Plata*, *Perez*, *Armstrong*, and *Coleman*, addressed plaintiffs' concerns about the 50-bed MHCB at CMC, stated that "[a]pproval of the construction agreement does not relieve defendants of their obligation to comply with this court's March 27, 2007 order."[58] The start of this critically needed MHCB project has nonetheless been delayed by at least a year. No patients will benefit from this yet unfunded project for many years.

33. I have been informed that two years after construction began in May 2006, CDCR opened the new CMF 50-bed MHCB facility to its first patients.[59] It is unclear how much this overdue resource will affect the massive backlog of patients waiting for higher levels of care. In my opinion, due to the effects of overcrowding on the delivery of mental health care, any reduction in the waitlists for higher levels of care will be temporary due to the pent-up demands in the system. During my site inspection at Wasco Reception center on August 1, 2008, the clinical staff in the CTC reported that they experienced difficulty referring their overflow crisis bed patients to the new CMF unit because their reception center prisoners do not have the medical work-up that CMF is requiring prior to transfer.

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[57] Coleman Pls.' Trial Ex. 57.

[58] Coleman Pls.' Trial Ex. 63.

[59] Coleman Pls.' Trial Ex. 64.

34. As problematic as the widespread use of these overflow beds is, CDCR is so overcrowded that it has not been able to create enough of them. Thus, there continue to be waiting lists to get prisoner/patients into these beds. For example, the State reported that as of November 1, 2007, there was a 108 person waiting list for beds at SVPP, even with the overflow D-5 and D-6 units operating.[60] The waitlist for the SVPP intermediate care DMH beds has continued to expand since November 1, 2007 with the most recent waiting list data [21] for July 31, 2008, listing 173 patients currently accepted and waiting for transfer to SVPP.[61] Recent documents from CSP-Sacramento show that ZZ beds, which are "contraband watch cells" were used as alternate sites for crisis beds patients *after* CTC beds, OHU beds, and MOHU beds were already full. These documents show that these cells are used regularly, with 62 admissions to ZZ cells and approximately 900 admissions to the MOHU in seven months.[62]

35. Similarly, at CIM during the 19th round of monitoring, the Special Master found that "there were 106 admissions to the Del Norte overflow MHCBs."[63] By the 20th round of monitoring, the number of admissions to the overflow MHCBs had increased to 384 and the Special Master noted: "[t]here were no physical plant modifications, and cells in Del Norte were inadequate for potentially sui-

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[60] Coleman Pls.' Trial Ex. 70.

[61] Coleman Pls.' Trial Ex. 78.

[62] Coleman Pls.' Trial Ex. 17.

[63] Joint Pls.' Trial Ex. 69 at 95.

cidal or agitated inmates. Large grate vents, unsafe bunk beds, and blind spots were not addressed."[64]

36. It also appears that some prisons are operating EOP units that are explicitly intended to be "temporary" because they are not appropriate for provision of this level of care. However, it seems inevitable that these units will continue to operate for years to come because of the current, overcrowding-driven bed shortage. This, in turn, has led to more interim measures being implemented to attempt to make these supposedly-temporary beds workable over the long term. For example, there is a "temporary" EOP mental health program operating at MCSP, and in March 2007, the Court approved defendants' *ex parte* request that they be permitted "to install adequate temporary treatment and office space to accommodate the existing and newly-opened Enhanced Outpatient Program mental health programs until replacement programs have been completed and occupied elsewhere in CDCR."[65] However, [22] even here, there have been delays in trying to make "temporary" space more adequate. Thus, to date, the temporary treatment space at Mule Creek State Prison has not yet been completed.[66]

37. In summary, as the *Coleman* Court noted throughout its July 23, 2007 Order, although some progress had been made over the years in the provision of mental health care in California prisons, this trend has been dramatically reversed by the overcrowding crisis.[67] Prisoners throughout the CDCR

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[64] Joint Pls.' Trial Ex. 57 at 263.

[65] Coleman Pls.' Trial Ex. 4 at 1-2.

[66] Coleman Pls.' Trial Ex. 55.

[67] Coleman Pls.' Trial Ex. 46.

are living in harsh and extreme conditions of confinement. As detailed throughout this declaration, and based on my observations and review of documents, I have concluded that overcrowding is now interfering with the ability of the CDCR to meet timelines for transfers to treatment programs at every level of care in its mental health system; it has resulted in an insurmountable shortage of clinical and custody staff; it has overrun all available treatment, office, and programming space; and combined with the environmental effects of overcrowding itself, these delays, shortages, and inadequacies in mental health care are exacerbating existing mental illness, and creating negative psychological consequences for prisoners who, but for overcrowding, would likely not exhibit these problems and symptoms.

B. The Effects of Overcrowding on Prisoners and Prison Systems

38. Overcrowding impacts every aspect of prison life. In addition to its direct, adverse effects on prisoners and correctional officers, chronic and severe overcrowding can precipitate reactions and adaptations that actually exacerbate its harm, leading to even more dramatic, even tragic consequences. That is, extreme and persistent levels of prison overcrowding force individuals and institutions to adapt in ways that are often counterproductive, and produce even more serious harm. Exposure to chronic and severe overcrowding has especially harmful effects on mentally ill and other vulnerable prisoners.

* * *

[41] 5. The Relationship Between Overcrowding and the Overuse of Segregation

75. As I already have noted, an unprecedented influx of prisoners compromises the meaningful evaluation and classification of incoming prisoners. In a severely overcrowded prison system like California's, a prisoner's security level and available bed space largely determine housing assignments. This means that many fewer new prisoners pass through an intake process that includes a comprehensive diagnostic evaluation and what—in the days of rehabilitation—was referred to as a "needs assessment." Thus, even chronic deficits in educational or vocational skills are overlooked or ignored in initial classification and subsequent housing assignments. Indeed, a chronically and severely overcrowded prison system for the most part lacks the resources with which to address the broad range of prisoner needs and problems anyway.

76. Among other things, this means that prison administrators have few incentives or positive rewards at their disposal with which to manage and control prisoner behavior. That is, overcrowded prisons lose their programming orientation and options. They are rarely in a position to offer well-behaved prisoners meaningful opportunities for personal growth or skill development, or participation in engaging activities or thriving organizations as "carrots" to reinforce and shape prisoner behavior. Lacking carrots, overcrowded prisons and prison systems rely increasingly on "sticks." Thus, overcrowding leads to increasingly negative forms of institutional control and, as population pressures mount, the use of harsh discipline and punishment tends to escalate.

77. The use of harsher and more punitive policies and procedures to maintain order and control means

that custody staff increasingly rely on security hardware and surveillance technology to control prisoner behavior. The extent of their dependence on the technology and implements of control has concerned some penologists, who worry about the "de-skilling" of correctional officers—the fact that interpersonal skills atrophy in prison systems where problems are solved and conflict defused increasingly by a reflexive tendency to lock up or lock down problematic or challenging prisoners (or the entire housing units in which they [42] reside). Indeed, overcrowded prisons may engage in the more frequent use of "lockdowns" and forms of disciplinary sanctions and segregation that further restrict prisoner movement and keep them separated from staff as well as one another. In California, as I will document in a subsequent section of this report, this includes the placement of troubled and troublesome prisoners—many of whom are mentally ill—in ASUs and SHUs.

78. Presumably designed to limit and control violence by keeping prisoners isolated from one another, segregated housing confines prisoners in especially harsh and deprived conditions for very long periods of time. Especially for mentally ill prisoners, this kind of confinement comes with a significant risk of psychological harm. As a general matter, psychologists know from studies of behavior and adjustment in free society that social isolation is generally bad for people's psychological well being.[111] Its effects are

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[111] For example, see: Graham Thornicroft, Social Deprivation and Rates of Treated Mental Disorder: Developing Statistical Models to Predict Psychiatric Service Utilisation, 158 *British Journal of Psychiatry* 475-484 (1991). Cf. Margaret K. Cooke & Jeffrey H. Goldstein, Social Isolation and Violent Behavior, 2 *Forensic Reports* 287-294, 288 (1989):

no more positive in prison. Thus, there is substantial evidence of the negative psychological effects of isolated confinement that comes from a variety of sources, including personal accounts, descriptive studies, and systematic research on solitary and supermax-type units. The data that establish these harmful effects have been collected in studies conducted over a period of several decades, by researchers from several different continents who had diverse backgrounds and a wide range of professional expertise.[112]

[43] 79. For example, mental health and correctional staff who have worked in disciplinary segregation and isolation units have reported observing a range of problematic symptoms manifested by the prisoners confined in these places.[113] The authors of one of the

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> A socially isolated individual who has few, and/or superficial contacts with family, peers, and community cannot benefit from social comparison. Thus, these individuals have no mechanism to evaluate their own beliefs and actions in terms of reasonableness or acceptability within the broader community. They are apt to confuse reality with their idiosyncratic beliefs and fantasies and likely to act upon such fantasies, including violent ones.

[112] For example, see: Christopher Burney, *Solitary Confinement*. New York: St. Martin's Press (1961); Frank Rundle, The Roots of Violence at Soledad. In Erik Olin Wright, (Ed.), *The Politics of Punishment: A Critical Analysis of Prisons in America* (pp. 163-172). New York: Harper (1973); Robert Slater, Psychiatric Intervention in an Atmosphere of Terror, 7(1) *American Journal of Forensic Psychiatry* 5-12 (1986); Slater, R., Abuses of Psychiatry in a Correctional Setting, 7(3) *American Journal of Forensic Psychiatry* 41-47 (1986).

[113] For detailed reviews of all of these psychological issues, and references to the many empirical studies that support these statements, see: Craig Haney & Mona Lynch, Regulating Prisons of the Future: The Psychological Consequences of Supermax

early studies of solitary confinement summarized their findings by concluding that "[e]xcessive deprivation of liberty, here defined as near complete confinement to the cell, results in deep emotional disturbances."[114] A decade later, Professor Hans Toch's large-scale psychological study of prisoners "in crisis" in New York State correctional facilities included important observations about the effects of isolation.[115] After hundreds of in-depth interviews with such prisoners, he concluded that "isolation panic" was a serious problem among prisoners in solitary confinement. Symptoms reported included rage, panic, loss of control and breakdowns, psychological regression, a build-up of physiological and psychic tension that led to incidents of self-mutilation.[116]

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and Solitary Confinement; and Craig Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, both *supra* note 7.

[114] Bruno M. Cormier & Paul J. Williams, Excessive Deprivation of Liberty, 11 *Canadian Psychiatric Association Journal* 470-484 (1966), at p. 484. For other early studies of solitary confinement, see: Gendreau, P., Freedman, N., Wilde, G., & Scott, G., Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement, 79 *Journal of Abnormal Psychology* 54-59 (1972); George Scott & Paul Gendreau, Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison, 12 *Canadian Psychiatric Association Journal* 337-341 (1969); Richard H. Walters, John E. Callagan & Albert F. Newman, Effect of Solitary Confinement on Prisoners, 119 *American Journal of Psychiatry* 771-773 (1963).

[115] Hans Toch, *Men in Crisis: Human Breakdowns in Prisons*. Aldine Publishing Co.: Chicago (1975).

[116] Toch noted that although isolation panic could occur under other conditions of confinement it was "most sharply prevalent in segregation." *Ibid* at 54. Moreover, it marked an important dichotomy for prisoners: the "distinction between imprisonment, which is tolerable, and isolation, which is not." *Ibid*.

[44] 80. More recent studies have identified other symptoms that appear to be produced by these conditions. Those symptoms include: appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilations. Moreover, direct studies of prison isolation have documented an extremely broad range of harmful psychological reactions. These effects include increases in the following potentially damaging symptoms and problematic behaviors: negative attitudes and affect, anxiety, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression, and rage, paranoia, hopelessness, a sense of impending emotional breakdown, self-mutilation, and suicidal ideation and behavior.[117]

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[117] For example, see the numerous studies cited in the articles referenced *supra* at note 7. In addition to those direct studies, and the many studies summarized in the literature reviews to which I have referred, there is a significant international literature on the adverse effects of solitary confinement. For example, see: Henri N. Barte, L'Isolement Carceral, 28 *Perspectives Psychiatriques* 252 (1989). Barte analyzed what he called the "psychopathogenic" effects of solitary confinement in French prisons and concluded that prisoners placed there for extended periods of time could become schizophrenic instead of receptive to social rehabilitation. He argued that the practice was unjustifiable, counterproductive, and "a denial of the bonds that unite humankind." In addition, see: Reto Volkart, Einzelhaft: Eine Literaturubersicht (Solitary confinement: A literature survey), 42 *Psychologie - Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen* 1-24 (1983) (reviewing the empirical and theoretical literature on the negative effects of solitary confinement); Reto Volkart, Adolf Dittrich, Thomas Rothenfluh, & Paul Werner, Eine Kontrollierte Untersuchung uber Psychopathologische Effekte der Einzelhaft (A controlled investigation on psychopathological effects of solitary confinement), 42 *Psychologie Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen* 25-46 (1983) (when prisoners in "normal" conditions of confine-

[45] 81. In addition, there are correlational studies of the relationship between housing type and various kinds of incident reports in prison. They show that self-mutilation and suicide are more prevalent in

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ment were compared to those in solitary confinement, the latter were found to display considerably more psychopathological symptoms that included heightened feelings of anxiety, emotional hypersensitivity, ideas of persecution, and thought disorders); Reto Volkart, et al., Einzelhaft als Risikofaktor fur Psychiatrische Hospitalisierung (Solitary confinement as a risk for psychiatric hospitalization), 16 *Psychiatria Clinica*, 365-377 (1983) (finding that prisoners who had been kept in solitary confinement were overrepresented as compared to other prisoners who were hospitalized in a psychiatric clinic); Boguslaw Waligora, Funkcjonowanie Czlowieka W Warunkach Izolacji Wieziennej (How men function in conditions of penitentiary isolation), *Seria Psychologia I Pedagogika* NR 34, Poland (1974) (so-called "pejorative isolation" of the sort that occurs in prison strengthens "the asocial features in the criminal's personality thus becoming an essential cause of difficulties and failures in the process of his resocialization"). See, also, Ida Koch, Mental and Social Sequelae of Isolation: The Evidence of Deprivation Experiments and of Pretrial Detention in Denmark, in *The Expansion of European Prison Systems, Working Papers in European Criminology No. 7* 119 (Bill Rolston & Mike Tomlinson eds. 1986) who found evidence of "acute isolation syndrome" among detainees that occurred after only a few days in isolation and included "problems of concentration, restlessness, failure of memory, sleeping problems and impaired sense of time an ability to follow the rhythm of day and night" (at 124). If the isolated confinement persisted—"a few weeks" or more—there was the possibility that detainees would develop "chronic isolation syndrome," including intensified difficulties with memory and concentration, "inexplicable fatigue," a "distinct emotional lability" that can include "fits of rage," hallucinations, and the "extremely common" belief among isolated prisoners that "they have gone or are going mad" (at 125). See, also: Michael Bauer, Stefan Priebe, Bettina Haring & Kerstin Adamczak, Long-Term Mental Sequelae of Political Imprisonment in East Germany, 181 *Journal of Nervous & Mental Disease* 257-262 (1993).

isolated, punitive housing units like ASUs and SHUs. So, too, are signs of deteriorating mental and physical health (beyond self-injury), other-directed violence, such as stabbings, attacks on staff, and property destruction, and collective violence.[118] Indeed, within CDCR, suicides are much more likely to occur inside the segregated housing units.[119]

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[118] For example, see: Howard Bidna, Effects of Increased Security on Prison Violence, 3 *Journal of Criminal Justice* 33-46 (1975); K. Anthony Edwards, Some Characteristics of Prisoners Transferred from Prison to a State Mental Hospital, 6 *Behavioral Sciences and the Law* 131-137 (1988); Lindsay M. Hayes, National Study of Jail Suicides: Seven Years Later. Special Issue: Jail Suicide: A Comprehensive Approach to a Continuing National Problem, 60 *Psychiatric Quarterly* 7 (1989); Elmer H. Johnson, Felon Self-Mutilation: Correlate of Stress in Prison. In Bruce L. Danto (Ed.) *Jail House Blues*. Michigan: Epic Publications (1973); Anne Jones, Self-Mutilation in Prison: A Comparison of Mutilators and Nonmutilators, 13 *Criminal Justice and Behavior* 286-296 (1986); Peter Kratcoski, The Implications of Research Explaining Prison Violence and Disruption, 52 *Federal Probation* 27-32 (1988); Ernest Otto Moore, A Prison Environment: Its Effect on Health Care Utilization, *Dissertation Abstracts*, Ann Arbor, Michigan (1980); Frank Porporino, Managing Violent Individuals in Correctional Settings, 1 *Journal of Interpersonal Violence* 213-237 (1986); and Pamela Steinke, Using Situational Factors to Predict Types of Prison Violence, 17 *Journal of Offender Rehabilitation* 119-132 (1991).

[119] In 2004, 73 percent of the suicides within CDCR prisons occurred in segregated housing. Docket 1806 at 7. In 2005, 37 percent of the suicides occurred in segregated housing and in 2006, 44 percent of the suicides occurred in segregated housing. Given the actual prison population that is housed in segregated units—less than 10,000 prisoners out of 165,000—the high number of suicides occurring among this small number of prisoners is quite staggering. In CDCR's own 2004 Suicide Report, they calculated the suicide rate for their administrative segregation population at *248 per 100,000*. Coleman Pls' Trial Ex. 164 at 15.

[46] 82. The use of extreme forms of solitary confinement in so-called "brainwashing" and methods of torture also underscores its painful, damaging potential. In fact, many of the negative effects of solitary confinement are analogous to the acute reactions suffered by torture and trauma victims, including post-traumatic stress disorder ("PTSD") and the kind of psychiatric sequelae that plague victims of what are called "deprivation and constraint" torture.[120]

83. The *prevalence* of psychological symptoms (that is, the extent to which prisoners who are placed in these units suffer from these and related symptoms) is very high. In my own study of a representative sample of prisoners in the Pelican Bay SHU, for example, every symptom of psychological distress that I measured but one (fainting spells) was suffered

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[120] Solitary confinement is among the most frequently used psychological torture techniques. In D. Foster, *Detention & Torture in South Africa: Psychological, Legal & Historical Studies*. Cape Town: David Philip (1987), Psychologist Foster listed solitary confinement among the most common "psychological procedures" used to torture South African detainees (at 69), and concluded that "[Given the full context of dependency, helplessness and social isolation common to conditions of South African security law detention, there can be little doubt that solitary confinement under these circumstances should in itself be regarded as a form of torture" (at 136). See, also: Matthew Lippman, The Development and Drafting of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 27 *Boston College International & Comparative Law Review* 275- (1994); Tim Shallice, Solitary Confinement—A Torture Revived? *New Scientist*, November 28, 1974; F.E. Somnier & I.K. Genefke, Psychotherapy for Victims of Torture, 149 *British Journal of Psychiatry* 323-329 (1986); and Shuan R. Whittaker, Counseling Torture Victims, 16 *The Counseling Psychologist* 272-278 (1988).

by more than half of the prisoners.[121] Many of the symptoms were reported by two-thirds or more of the prisoners in this isolated housing unit, and some were suffered by nearly everyone. Well over half of the SHU prisoners reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that is commonly associated with hypertension. I also found that almost all of the prisoners evaluated reported ruminations or intrusive thoughts, an [47] oversensitivity to external stimuli, irrational anger and irritability, difficulties with attention and often with memory, and a tendency to socially withdraw. Almost as many prisoners reported a constellation of symptoms indicative of mood or emotional disorders—concerns over emotional flatness or losing the ability to feel, swings in emotional responding, and feelings of depression or sadness that did not go away. Finally, sizable minorities of the prisoners reported symptoms that are typically only associated with more extreme forms of psychopathology—hallucinations, perceptual distortions, and thoughts of suicide.

84. Unless a prison system steadfastly guards against it—and few overcrowded prison system are able to—certain categories of vulnerable prisoners are likely to be placed disproportionately in these units where, precisely because of their vulnerabilities, they are at greater risk of suffering serious harm. For example, one commentator has described the "vicious cycle" into which mentally ill and developmentally disabled[122] prisoners can fall when

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[121] Craig Haney, Mental Health Issues in Long Term Solitary and "Supermax" Confinement, *supra* note 7.

[122] I have not focused specifically on developmentally disabled prisoners in this report. However, they, too, are especially

they commit disciplinary violations and are placed in segregated housing. A lack of appropriate treatment and care in general population may worsen their condition, "[c]ausing hostile and aggressive behavior to the point that they break prison rules and end up in segregation units as management problems." Because of highly stressful conditions in segregation and the fact that mental health care is usually sporadic and of uneven quality there, "this regression can go [48] undetected for considerable periods of time before they again receive more closely monitored mental health care." Unfortunately, this is a cycle that "can, and often does, repeat.[123]

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vulnerable to the negative consequences of overcrowding, in part because of the deteriorating living conditions with which they must contend and the reduced number of options that they may have with which to adapt. For example, as one observer put it, "A prisoner with mental retardation whose circumstances have placed him or her among brighter peers without support may well learn to survive through aggression." Hall, J., Correctional Services for Prisoners with Mental Retardation: Challenge or Catastrophe? (pp. 167-190). In Conley, R., Luckasson, R., & Bouthilet, G. (Eds.), *The Criminal Justice System and Mental Retardation* (pp. 167-190). Baltimore, MD: Brooks (1992), at p. 172. Other studies have confirmed this. For example: "[R]esearch evidence has suggested that the mentally retarded are slower to adjust to the prison routine, have more difficulty learning rules and regulations, and as a result, accumulate more rule infractions than the average prisoner." Finn, M. (1993). Disciplinary "Careers" of Mentally Retarded Prisoners, 19 *Journal of Offender Rehabilitation* 57-73 (1993), at p. 60. Precisely because overcrowded prisons enforce more stringent and unyielding routines, increase prisoners' frustration, and generate more potential conflicts, developmentally disabled prisoners are more challenged to avoid rule infractions.

[123] Streeter, P., Incarceration of the Mentally Ill: Treatment or Warehousing? 77 *Michigan Bar Journal* 166 (1998), at p. 167.

85. Indeed, in my own research, I found a higher percentage of prisoners who suffer from serious forms of mental illness residing in isolated or segregated housing, as compared to their numbers in the general prison population. Other researchers have found the same kind of high prevalence rates. For example, a Canadian study estimated that approximately 29 percent of prisoners in special handling and long-term segregation units suffered from "severe mental disorders."[124] A more recent study conducted by a group of Washington state researchers also found that 29 percent of intensive management prisoners in the state's correctional system manifested at least one pre-defined indication of serious mental disorder (such as multiple admissions to an acute care mental care facility, or having been in one of the prison system's residential mental health units).[125] California's segregated housing units also contain a disproportionately high concentration of mentally prisoner/ patients. Thus, in the CDCR, although mentally ill prisoners comprise less than 25 percent of the overall prison population, by August 2007, 46 percent of the prisoners housed in the administrative segregation units were on the mental health caseload.[126]

86. Unfortunately, as I have already suggested, the overrepresentation of mentally ill prisoners in isolation units like ASUs and SHUs is potentially

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[124] Hodgins, S., & Cote, G., The mental health of penitentiary prisoners in isolation, 33 *Canadian Journal of Criminology* 177-182 (1991).

[125] Lovell, D., Cloyes, K., Allen, D., & Rhodes, L., Who lives in super-maximum custody? A Washington State study, 64 *Federal Probation* 33-38 (2000).

[126] Coleman Pls.' Trial Ex. 81.

dangerous and damaging. All other things being equal, it also is a problem that is more likely to plague overcrowded prison systems than others. There are several reasons why this is so. For one, these systems typically [49] lack adequate treatment resources and programs to effectively monitor and manage mentally ill prisoners in the general population. The mental health of those prisoners is likely to worsen in the absence of appropriate treatment, and their problems are likely to become more serious before they are detected and addressed. In addition, the severe conditions of confinement that accompany overcrowding place special stressors on mentally ill prisoners that may worsen their conditions and lead to decompensation. Moreover, overcrowded prison systems are more likely to resort to punitive forms of social control than others, so that if and when mentally ill prisoners do violate prison rules in an overcrowded prison, those violations are more likely to occur in prisons that are more prone to punishment.

87. Yet, as I have suggested, the placement of mentally ill prisoners in ASUs and SHUs places them at risk. It represents one of the critically important ways in which mentally ill prisoners can be damaged and harmed by overcrowded conditions of confinement—not just by the overcrowding to which they are directly exposed, but by the practices and reactions that the larger prison system has developed in response to the overall pressure and dysfunction that overcrowding brings about. As I will discuss in greater detail below, during my site inspections of the administrative segregation units, staff reported and I observed inadequate treatment space, insufficient staffing resources, inadequate access to exercise and yard, lack of programming and poor access to higher

levels of care when these prisoners decompensated in these harsh environments.

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2. Personal Tours of Eight Severely Overcrowded California Prisons

98. As I mentioned at the outset of this report, in order to gain a firsthand understanding of some of the consequences of overcrowding in the CDCR, I conducted tours and interviews in numerous housing units located in eight prisons where *Coleman* class members reside. I spent a full day at each of the eight prisons, and visited a representative sample of mainline housing units. During my tours I had open access to medical, custody and mental health staff, prisoners, medical and custody records, staffing and construction information, logs of delayed access to care and any additional information that I requested. Custody and clinical staff responded openly and honestly to my questions and no one tried to block me from reviewing any files or documents or from speaking with anyone in the prison. The housing units I visited included ones most affected by the severe overcrowding in CDCR (e.g., housing units that had been converted into makeshift dayroom and gymnasium dormitories), ones that contained specialized mental health and crisis beds, and segregated housing (including the SHUs at Valley State and CCI). I also spoke with prisoners in each of the housing units and interviewed a sample of prisoners at each facility selected from lists of CCCMS and EOP prisoners at the prison and from correspondence with Plaintiffs' counsel.

99. I should say at the outset of this section of my report that virtually every one of the overcrowding-related harmful conditions, negative consequences, and dysfunctional adaptations that I described in general terms earlier in this report—at least the ones that could be seen in the course of a prison tour—was in evidence at the eight prisons I visited. The nexus [57] between severe and chronic overcrowding as the primary cause of the continuing constitutional violations was clearly apparent and disturbing. Specifically:

a. California Institution for Men (CIM)

100. CIM is a large, sprawling, prison complex consisting of four separate facilities under the administration of one warden. CIM serves as a Reception Center for parolees returning to custody and new commitments to the CDCR. According to the CDCR population report as of midnight on October 31, 2007, CIM had a population of 6,315 and a design capacity of 3,033, for a population at 208 percent of capacity.[147]

101. Administrative Segregation units ("Ad Seg" or "ASUs") are located in Palm Hall, Cypress and sections of Birch. The EOP Reception Center prisoners are housed in various locations, including RC Central, RC East, and Ad Seg units.

(i) CIM Overview

102. On the day I toured CIM (October 29, 2007), Warden Poulous reported that the count was approximately 6,900 prisoners, well over 200 percent of its rated capacity of 3,160.

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[147] Joint Pls.' Trial Ex. 25 at 2.

[60] (iii) Inadequate Space, Suicidal Transfer Delay and Lack of Medical Records.

106. At CIM-East, a staff psychiatrist who sees about 25-30 prisoners a day—all of whom are on psychotropic medications—told me that when the CIM MHCB, located in a different part of the prison, to which he typically admits patients is full, they are transferred to "temporary" and "overflow" housing. This happened as recently as ten days ago. He also told me that although he has the patient's records most of the time, "sometimes I don't," and when this happens he is forced to make treatment decisions without them. Moreover, he often experiences a delay in getting suicidal patients transferred—"either the custody staff is tied up or, now that we take them in an ambulance, the ambulance is otherwise occupied and they have to wait." While the patients wait for transfer to the CTC or the overflow unit, they are kept in five small holding tanks—cages—in a room in the administrative building. There were five single man "dry" cages (no toilet or sink) and two were occupied. The psychiatrist told me that suicidal prisoners are placed there about four to five times a day and custody officers confirmed that the cages are used for suicidal patients.

(iv) Use of Dangerous Overflow Units for MHCBs.

107. Later in the day I visited the "temporary" and "overflow" beds in Del Norte that are used when

the MHCB is full. The 10-bed unit is called the TBH (Temporary Bed Housing). The TBH unit that is regularly used in Del Norte was under construction and closed. I was shown another 5-bed unit on the other side of the dayroom, which I was told was identical to the old "temporary" overflow unit. These "temporary" beds for housing suicidal prisoners had bunk beds, stools under the sink and large, mesh ventilation screens, all of which [61] could be easily used to attach a ligature for hanging. I asked staff if the construction on the older "temporary" overflow beds was going to include suicide-proofing the cells (removing the bunks, replacing the large mesh ventilation screens, removing the stools), but I was told "no."

108. The Special Master has also identified serious problems with CIM's MHCB units, including overcrowding in the unit (the "average daily census [in the MHCB] increased from 31 to 34.6, or 16 above licensed capacity") and staffing shortages: "MHCB staffing was allocated for 18 beds, while the unit served 36 prisoners within several different areas, including overflow areas on East yard and Cypress, and sometimes an area of the CTC. The 18 unlicensed beds plus the overflow beds were covered by diverting other staff."[157] In the 19th Report, the Special Master noted that overflow MHCB areas were operational in two of the reception center units, in Del Norte and in Birch Hall, with 106 admissions to the Del Norte overflow MHCBs in March 2007 alone.[158] This overflow unit in Del Norte was "inadequate for potentially suicidal or agitated inmates . . . The cells had large-

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[157] Joint Pls.' Trial Ex. 36 at 233-234.

[158] Joint Pls.' Trial Ex. 69 at 95.

grate vents, unsafe beds and blind spots."[159] Similar problems were noted in the Draft 20th Report; CIM clinicians admitted 384 patients to the two overflow MHCB areas during the monitoring period.[160] Despite the frequent use of this overflow unit, no physical plant modifications were made to the unsafe overflow cells located in the Del Norte MHCB overflow unit.[161]

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[75] b. Valley State Prison for Women (VSPW)

(i) VSPW Overview

134. Valley State Prison for Women is one of three CDCR prisons housing women in the state. VSPW has a reception center, mainline, SHU and Ad Seg units, and an OHU. It does not have a licensed CTC, but rather has an unlicensed infirmary (OHU). CCCMS prisoners are mixed throughout the reception center and on other yards. VSPW has no regular EOP program, but has an Ad Seg EOP Hub. The Special Master Reported in the 18th Monitoring Report that in January 2007, 26 percent of VSPW's prisoners were participants in MHSDS, with 1,004 MHSDS participants and 3,806 total prisoners.[203] These numbers have increased. Thus, according to the most recent data provided by defendants, VSPW had 1143 participants in the MHSDS on June 20, 2008, including 1129 3CMS (151 percent of their 3CMS capacity) and 14 EOPs (156 percent of their EOP capacity).[204]

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[159] *Id* at 96.

[160] Joint Pls.' Trial Ex. 57 at 263.

[161] *Id.*

[203] Joint Pls.' Trial Ex. 36 at 297.

[204] Coleman Pls.' Trial Ex. 57.

135. When I visited Valley State Prison for Women (on October 30, 2007), it housed 3,810 women in a facility designed for approximately 2,000. On the CDCR website, VSPW's population was listed as 4,022 women as of July 30, 2008, which was 203.7 percent of its design capacity of 1,980.[205] Although some of the VSPW staff talked proudly about their compliance with the requirements of *Coleman*, my observations of the prison and conversations with staff and prisoners revealed much at the prison to be concerned about. There are many problems there that stem from the severe overcrowding and the corresponding lack of treatment space that characterizes the facility. Among other things, their medical and mental health treatment areas are cramped and inadequate. I was told that they have had as many as 90 prisoners in the waiting room area which, as the Chief Medical Officer noted, is a [76] direct result of overcrowding at the prison. She also noted that the prison lacked appropriate long-term treatment options for women with very serious mental health problems.

(ii) Treatment and Office Space and Staffing

136. During my visit, I was told by the Acting Chief of Mental Health that VSPW recently has been able to hire significant numbers of new mental health staff due to salary increases, but that the institution does not have the office and treatment space to appropriately accommodate these new employees. Months after my tour, this problem continues to plague the institution. Thus, on April 21-23, 2008, nearly six months after my visit, the prison staff stated that "[t]he primary challenge facing the mental health as well as the entire healthcare department

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[205] Joint Pls.' Trial Ex. 59.

remains the severe lack of space. Dental, Mental Health and Medical must compete for space in areas that were never intended to house and treat the current inmate- patient population."[206] Despite having requested "immediate relief for the lack of space at VSPW," the prison reported "[n]o progress has been made with this to date."[207] This general problem applied more specifically to the Reception Center, where "[t]here are ongoing and serious problems related to office space for treatment/evaluation."[208]

137. During my tour I routinely heard from staff that space is the "number one challenge" at VSPW. One senior clinician told me that they were "crawling all over each other"—and documents drafted by the institution for the *Coleman* monitoring team that I reviewed confirmed these comments. All clinical staff members were sharing offices, including some senior staff members who had tripled up on offices. The institution was so short of treatment space that I was told storage rooms were being converted to this use. Although the institution did offer some groups, mental health staff reported that the groups were virtually always full and always had long waiting lists. I was told that VSPW has had to [77] shorten the number of weeks that each group cycle lasts in order to be able to get more prisoners through them. Worse, still, some prisoners I interviewed reported that sometimes a group session or "hour" lasts for only five to ten minutes. When prisoners complain, they are told that groups cannot be scheduled for

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[206] Coleman Pls.' Trial Ex. 90 at p.1.

[207] *Id.*

[208] *Id.*

different times or longer periods because the space is being used for something else. One prisoner in B-yard reported that there had been no groups except a lifer group in more than three months.

138. When I met with one of the clinicians who directs the reception center mental health program, she explained that staff members in this area also do not have enough office space. Screening of many of the prisoners who arrive without urgent issues actually took place in the dining hall—obviously non-confidential—but she explained that there is no other space to go into because prisoners are housed in dayrooms in the reception center.

139. Staffing vacancies and the reliance on contractors remains a problem at VSPW. In the April 2008 monitoring documents, the prison reported 18.88 clinical vacancies, with contractors covering a small percentage of those vacancies.[209] In June 2008, the prison reported similar vacancy rates of 18.05 clinical positions, with 2.4 of those vacancies covered by contractors.[210] The majority of the vacancies were psychologists and social workers who provide case management services to the reception center and mainline mental health caseload prisoners.[211]

140. The Corrective Action Plan also acknowledged a continuing "[l]ack of individualized treatment plans with coherence between diagnosis, plan and treatment provided," an area where improvement was reflected in the previous audit but not in the current one. The identified obstacles included "[l]ack of group

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[209] Coleman Pls.' Trial Ex. 90.

[210] Coleman Pls.' Trial Ex. 91.

[211] *Id.*

treatment," and "[l]ack of staff to provide therapy as dictated by program [78] guide."[212] In this area VSPW noted "compliance rates appear to have fallen from the review done on 9/1/07."[213] Among the reasons given for decreased compliance were possible audit problems, the number of newly hired clinicians who required additional training, and the increased volume of evaluations required for the reception center prisoners.[214]

(iii) Overcrowding in Housing Units, Dayrooms and Gyms

141. As was true of all of the prisons I visited, the overcrowding at VSPW has necessitated use of housing arrangements and configurations that are extremely troublesome and that subject the prisoners to conditions of confinement that are potentially dangerous and psychologically damaging. These kinds of housing arrangements are especially problematic for prisoners who suffer from pre-existing mental illness or possess special psychological vulnerabilities. For example, a number of the housing units at VSPW now use their dayrooms as makeshift dormitories where prisoners are double-bunked.

142. In the standard VSPW housing unit, 40 such bunks (housing 80 prisoners) have been placed in the dayroom, significantly increasing the number of prisoners living in the unit and, at the same time, significantly degrading the overall living conditions

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[212] Coleman Pls.' Trial Ex. 90 at 33.

[213] Coleman Pls.' Trial Ex. 90 at 34.

[214] *Id.*

there (both for the women in the makeshift dorms and those in other parts of the unit). In addition to subjecting the prisoners who are housed on these open bunks to marginal and degraded living conditions, the presence of the bunks deprives the other women in the housing units of the opportunity to use the dayrooms for their intended purpose. Indeed, officers told me that, prior to the introduction of the dayroom dorms, prisoners were allowed to use the dayrooms for recreation and a number of constructive activities throughout the day; now they get about 4 hours of recreation time, which must all be spent in the yard outside the unit.

[79] 143. As problematic as the dayroom dorm housing appeared, the 8-person rooms in which many of the VSPW prisoners lived were equally if not more cramped. In fact, many of the women said that they actually preferred the dayroom dorms to the 8-person cells for safety reasons—they told me that when the doors were closed and the women were locked in the close quarters of the cells, there was little or no opportunity for staff to monitor what went on inside. With four double bunks, one toilet, one shower, and two sinks crammed into each cell, it could be likened to living in a steamy shower stall.

144. A number of the women at VSPW told me that they felt closed in and claustrophobic in these cramped and crowded quarters. One CCCMS prisoner told me: "I have a hard time around people—in the housing unit, yard, everything is so crowded here—I don't do anything but sit in my cell. I used to go to yard or dayroom but not now. I just want to be away from people." Staff at VSPW reported that they do not consider CCCMS status in their housing decisions in

these units, so CCCMS prisoners are spread throughout both dayrooms and cells.

145. Out of three reception center housing units, two of them were configured with the 8-person dorm rooms mentioned above *plus* the double bunks in the dayroom. The other reception center housing unit had double cells along with the double-bunks in the dayroom. However, at the time of my visit, these were unoccupied (although the prisoners I talked to reported that this was not always the case). They also reported that some of the cells in this unit are used as overflow Ad Seg housing, and that they had been used for this purpose as recently as two weeks prior to my visit. When Ad Seg prisoners are housed in this unit, then the reception center prisoners do not receive dayroom, and must choose between taking showers or going to yard.

146. Just as many other CDCR facilities have, VSPW resorted to housing prisoners in makeshift gym dormitories. The gym that I observed currently houses 200 prisoners in double-bunks. The atmosphere is very much like that in the men's prisons where the gymnasiums have been converted into housing units. The women in the gym dormitories at VSPW were at least afforded metal lockers in which to keep their property (an improvement over the paper [80] bags provided to the men in CIM gym dorms). However, they still had no real privacy in this huge dorm. The women live on open bunks that also stretch out across a huge area that is impossible to monitor. Women must use the shower stalls and toilets in plain view of one another, and the ventilation ducts and cross beams on the ceiling of the gym appeared to be filthy with some kind of material that resembled insulation; many of the women complained to me

about it and said that pieces or particles of it dropped on them from time to time. At the time of my visit, 5 out of the 17 toilets had "out of order" signs on them.

(iv) Security Housing and Administrative Segregation Units

147. The Security Housing and Administrative Segregation Units at VSPW were severe and especially problematic for *Coleman* class members, a fairly large number of whom were housed there. In fact, we were told that out of the 63 prisoners housed in the SHU, more than half were on the mental health caseload, with 34 CCCMS and 2 EOP. In Ad Seg, roughly 25 percent were on the mental health caseload, with 28 CCCMS and 2 EOP out of 129 total prisoners. Unfortunately, the population of mentally ill prisoners in the SHU and Ad Seg units has not been reduced since my visit in October 2008.[215] The Ad Seg unit sergeant was unclear about how often mental health staff members actually came into the unit. He also indicated that "groups run all day" and that both CCCMS and EOP prisoners have access to groups. However, the prisoners told me a different story. For example, I learned that the group that was taking place on the unit on the day of my visit—which consisted of several women standing in treatment cages that were arrayed in a semi-circle in a separate room off the unit dayroom—was the only one that they knew about that was available to CCCMS prisoners. Moreover, they told me that this was its first meeting. The women reported more generally that access to groups for EOP prisoners

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[215] The Ad Seg MHSDS population was 24 3CMS and 6 EOP and the SHU MHSDS population was 33 3CMS and 2 EOP. Coleman Pls.' Trial Ex. 57.

was sporadic at best. In addition, I learned from staff as well that, when one-to-one clinician contact occurred, it took place on the open dayroom floor. On the [81] day of my visit, the prisoners in the Ad Seg unit did not receive any yard, apparently due to a faulty gate lock. However, we received mixed reports about whether yard was regularly provided for prisoners in the Ad Seg unit.

148. Here, too, there were concerns expressed by prisoners about whether and how they were being prepared for their release from prison. One VSPW prisoner who has been diagnosed as psychotic and is on the EOP caseload told me: "I am scared about my fate when I get out. Am I going to be a zombie who has to be on big doses of medicine to function at all?" She complained about the fact that groups are sometimes cancelled—"sometimes we have only one group for the whole week"—and also about the lack of meaningful content in the groups themselves, which she said often consisted of nothing more than watching Animal Planet or Disney Channel television shows.

149. Prisoner JJ, another VSPW prisoner on the EOP caseload told me that she had been either in SHU or Ad Seg for virtually her entire prison term—a total of approximately 6 years. She said that she had been kept in these segregated units despite that fact that she was diagnosed as schizophrenic, had serious enough mental health problems in the free society to have been sent to Patton State Hospital, and was taking Haldol at the time I interviewed her. More troubling still, she felt that she had received little or no help during her incarceration (in part because she had been kept segregated for virtually her entire time in prison) and yet she was scheduled for release in less than a month. She voiced com-

plaints both about the content of the groups she had attended as well as the circumstances under which they were held: "They have groups for EOP—we stand or sit in cages and watch TV. It doesn't help me and so I don't come out." In light of her imminent release from prison, and the fact that "nobody has helped me with my release," she was extremely concerned about what was going to happen to her. I reviewed portions of Prisoner` JJ's records and confirmed that she did have a history of treatment at Patton State Hospital and at EOP level of care.[216] She had been housed in [82] administrative segregation or SHU for most of her prison time, with some periods in the crisis unit or in EOP programs. She also had a history of suicide attempts. She was placed in administrative segregation when she returned to VSPW on a parole revocation in March 2007 and was housed there when I saw her. She had multiple crisis bed admissions for suicidal ideation and was treated at the EOP level of care until she paroled out on January 4, 2008. Her records reflect that she returned to VSPW on a parole violation on February 27, 2008 and was placed on EOP level of care in the reception center.[217] On March 4, 2008, she was reviewed in her treatment team and was retained at EOP level of care. Less than a week later, on March 10, 2008, she was recommended by her clinicians for removal from EOP despite clinical notes that described her with: "affect was blunted," and as "less compliant with groups" and complaining of "intermittent fearfulness and paranoia."[218] A chrono in her file showed that she was at an EOP level of care on

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[216] Coleman Pls.' Trial Ex. 92.

[217] *Id.*

[218] *Id.*

March 9, 2008, and 3CMS on March 10, 2008. Despite the reduction in her level of care, she was followed weekly by her case manager but was no longer provided with the ten hours of group therapy available to EOP prisoners. Her medications were changed several times and she was described as having a "childlike disposition."[219] On June 16, 2008, she was involved in an incident in her housing unit, which the officer writing up the rules violation described as a mixed housing unit for reception center and administrative segregation overflow prisoners. She ignored an order to stop walking toward the door, and the officer used physical force on her. I could not tell from the records whether this rule violation resulted in a DA referral or other sanctions.

[83] c. Salinas Valley State Prison (SVSP)

(i) SVSP Overview

150. Salinas Valley is a Level III/Level IV high security prison located south of the city of Salinas in the Salinas Valley. According to CDCR population data as of midnight October 31, 2007 SVSP had a population of 4,093 and a design capacity of 2,372; it was operating at 173% of capacity.[220] Its population also remains high—somewhat higher than at the time I visited. CDCR website's listed SVSP's population as of midnight July 30, 2008 as 4,116, with a slightly increased design capacity of 2,388.[221] Since my visit in November 2007, there have been two additional suicides at the prison—one in administra-

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[219] *Id.*

[220] See Joint Pls.' Trial Ex. 25 at 2.

[221] Joint Pls.' Trial Ex. 59.

tive segregation and one on a general population yard.[222]

151. I toured Salinas Valley State Prison (SVSP) on November 1, 2007.

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(ii) MHCB Access

155. During the morning meeting, Dr. Lee reported that although there are 8 MHCB beds in the Correctional Treatment Center, some of these beds are routinely filled by medical patients. As a result, the prison has been forced to continue its use of "overflow" MHCB beds. The Special Master has found that "[s]tandard CTC procedures resulted in heavy use of both types of cells and many overnight stays in large holding cells. Logs of holding cell use maintained by custody and nursing staff were incomplete . . . Staff reported that holding cells located in the yards were rarely used after September 2006, but those in the treatment and [87] triage area of the CTC were in use daily and frequently housed prisoner overnight. The holding cells in daily use were stand-up mesh cells."[234]

156. When I toured the CTC, I spoke with Dr. Chase, the CTC psychologist in charge of the unit. She reported that the MHCBs are always full, sometimes necessitating the use of "overflow" beds, as well as "holding arrangements" consisting of wet cells, dry cells, and holding cages for prisoners who are awaiting admission into the unit. According to

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[222] Coleman Pls.' Trial Ex. 85; Coleman Pls.' Trial Ex. 95.

[234] Joint Pls.' Trial Ex. 36 at 153.

Dr. Chase, although the prison houses over 1500 mentally ill prisoners, not all of the 8 MHCB beds are available for mental health prisoners because they are occupied by medical patients. As a result, the prison must sometimes place prisoners in the holding cells for several days or refer them to an outside MHCB unit. Dr. Chase reported that the "dry cells," which are tiny, freestanding upright cages with mesh wiring surrounding them (and no toilet), are used during the day to house suicidal prisoners until an MHCB bed becomes available. During the tour of the CTC, there were three men housed in these tiny "dry cells," all of whom were waiting for administrative hearings for involuntary medication orders. At night, those prisoners not already transferred into an MHCB bed are transferred into a "wet cell," one of the four holding cells outside the entrance of the CTC which have toilets. The longest stays that Dr. Chase recalled were from Thursday evening to a Monday morning. Clinical staff also reported that they routinely use "BPT cells" located on each yard for overflow suicide watch.

157. In addition, the shortage of DMH beds in the system means that prisoners who should be prioritized for transfer to inpatient care wait for inordinate periods of time. A tragic example was the paraplegic prisoner I saw in the CTC who had been on a hunger strike since July and had been awaiting transfer to an acute DMH bed for several weeks.

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(viii) Custody and Clinical Staffing Problems in ASUs

175. One of the psychologists who accompanied us for part of my tour of SVSP told me that his ASU caseload was about 50—a figure that he characterized as "too many" because it made it impossible to see them all on schedule.[264] He also told me that "we want to hold CCCMS groups but we have no staff, no space, and no escorts." Prisoners in a caged "group therapy" session taking place in the D Yard ASU told me that they were given a choice each day whether they wanted to go to group or to yard, but not to both. They also complained about a lack of mental health training and responsiveness on the part of the custody staff: "Sometimes we feel depressed in our cells. We tell the officers, but they ignore us. They tell you they want to see blood, or they tell you, 'we'll give you the rope.'" Prison staff reported during the 21st round monitoring tour that only 50 to 60 percent of the prisoners in administrative segregation were provided with confidential out-of-cell case manager meetings.[265] The obstacles to providing these confidential out-of-cell clinical meetings included "limited space available for confidential out of cell interviews," staff coverage during vacations and absences, and tight scheduling in the Ad Seg units.[266]

[98] 176. One of the rooms that I saw at SVSP that was set aside for the caged "group therapy" that takes place in the ASU was truly degrading. The room in which some 10 or so therapy cages were located appeared to be a laundry room, with huge

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[264] Coleman Pls' Trial Ex. 57 (On June 20, 2008, the MHSDS population (EOP and 3CMS) in the ASUs at SVSP was reported as 248).

[265] Coleman Pls.' Trial Ex. 138 at 92.

[266] *Id.* at 95.

trays of laundry in the background and large storage shelves—a large, dirty industrial or factory-like setting that the caged prisoners looked out on during their sessions. In addition, the cages themselves were filthy, with rusted metal and graffiti on the sides of the cages and the tops of the small tables inside. A prisoner who was being held in one of the cages, presumably waiting for the rest of his "group," told me: "I'm just in a cage back here [in ASU]—I've been kept here for several weeks but had no yard, no group, no nothing." The Special Master noted the EOP high refusal rates for group therapy and described the group therapy rooms where "[i]n one of the two rooms . . . cells were arranged in a straight line . . . [i]n the other room, noise from nearby machinery was problematic."[267]

177. In another similar unit, a custody staff member told me that he could not run the yards for prisoners on the appropriate schedule because he simply lacked the manpower with which to do it: "I don't have single escorts to run the psych, doctor, CTC escorts. I don't have the staff. I am short at least 2 officers." This unit also lacked appropriate treatment space for *Coleman* class members to receive their mandated clinical contacts. They had only two holding cages near the entrance to the housing unit, and an individual office that contained another cage inside it.

178. I visited D-8, an Ad Seg housing unit where the majority of prisoners are CCCMS. I spoke with the Sergeant, who discussed some of the problems that he faces in the unit because of staffing shortages and the inadequate number of walk-alone yards for Ad Seg prisoners. This Sergeant described how the

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[267] Joint Pls.' Trial Ex. 57 at 185.

majority of prisoners in his unit were on walk-alone status, but there were no walk-alone yards on his yard. (The "walk-alone yards" are actually outdoor exercise cages.) He explained that in order for the men on walk-alone status [99] in his unit to receive outside exercise, they have to be placed in restraints and waist chains, escorted out of their cells and out of their housing unit, and taken by correctional officers all the way to another yard on Facility D, where they are put in individual cages and allowed to exercise. When their exercise time is over, they are chained up again and escorted back to their unit and into their cells. He stated that he needed additional correctional staff in order to run the yard, medical, mental health and the regular Ad Seg program.

179. A disturbing suicide occurred in the Ad Seg unit, D2, on January 10, 2008, when a 3CMS prisoner hung himself from the top bunk of his cell.[268] This prisoner was housed for a long period of time in the harsh conditions of Ad Seg and had "become more isolative and withdrawn, refused out-of-cell contacts" as the months passed and his promised transfer from Ad Seg to SATF general population did not materialize. He refused to come out of his cell for treatment and other activities. Progress notes documenting the last two cellfront visits with his case manager were missing from his medical records. When he was discovered by custody officers, CPR was not initiated immediately and according to the records, when the watch commander requested medical assistance via radio from medical staff in Facility D, the records note: "Be advised, medical staff are refusing to respond." Other problems were identified in the Suicide Report, including the fact that this prisoner

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[268] Coleman Pls.' Trial Ex. 95.

was transferred in error from Lancaster back to SVSP where he had been charged with attempted murder of an officer and remained there until his death. Overcrowding contributed to the problems identified in this tragic case: his transfer to his endorsed prison was delayed; classification mistakes were made when he was returned to SVSP; this decompensating prisoner was retained in Ad Seg with little intervention by clinical staff; and, custody and medical staff failed to appropriately and timely respond to the emergency.

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d. Mule Creek State Prison (MCSP)

(i) MCSP Overview

181. I toured Mule Creek State Prison on November 2, 2007.

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(iii) Staff Concerns Related to Overcrowding

186. Everywhere I went in this prison the clinical staff voiced concerns about inadequate space. In the B Facility mental health program building, clinicians need to schedule shared rooms for individual interviews or treatment. The clinical staff shares offices—one standard size office is used by four different psychiatrists and is also where all of the medical records are stored. Another office houses 7 or 8 recreational therapists, and there were 6 nurses using another small office. A psychiatric technician candidly explained the shortage of treatment space impacted the prisoners on the mental health caseload: "Even though we don't have the dayrooms full of beds, these

are mentally ill prisoners, many of whom are paranoid. They get frightened and withdrawn because of the overcrowding. There is nowhere for them to have privacy. There are people everywhere on the unit and the prisoners are suffering because of it." She went on to say that: "I can see it in the tension in the yard, the apprehension of the prisoners—there are men who are afraid to go out—they have other prisoners accompany them."

187. In fact, the psychologist who accompanied me on the tour spoke candidly as we left this area. She told me that her clinical staff is very concerned about their ethical and legal and professional standards being compromised, "the staff is doing its best, but . . . as a clinician, this is a very, very serious situation—you know what I mean." When I asked her if she would elaborate, and tell me how overcrowding was affecting the staff's ability to "ethically, legally, and professionally" do their job, the assistant attorney general on the tour informed me that I was not allowed to ask such a question. "If you want her opinion on that, depose her," as she put it.

[106] 188. It was obvious that one of the overriding concerns among the clinicians was the quality of treatment that they could provide under the conditions that prevailed at the prison, given the lack of usable and appropriate treatment and office space, staff vacancies, and the overwhelming numbers of prisoners. Many of the treatment areas I saw at Mule Creek lacked even a modicum of privacy and, even when there were cubicles and partitions, it was possible to overhear what was being said. For example, two groups were underway when I entered the B Annex and the prisoners were talking in hushed

tones, presumably in an unsuccessful attempt to keep the content of the group confidential.

(iv) Overcrowding and Housing Units

189. Prisoners on the MHSDS caseload are housed in the "non-traditional" beds, which include dayroom and gyms with *triple bunks*. The makeshift gymnasium dormitory on B Facility is similar to those at the other prisons I visited, except that there are triple bunks, and all levels are filled with prisoners. Staff reported that there are three gyms filled with these bunks at MCSP. The correctional officer on duty in the B Facility gym told me that they tried to insure that only about a third of the prisoners were in the dorm at any one time, except for count and when everyone returned to the dorm in the evening. Prisoners who feel they are unable to tolerate dormitory housing like this can request an exemption; however the correctional staff member and the clinician who accompanied me on the tour both agreed that it was rare that such an exemption would be granted, in part because there were too few alternative housing spaces to accommodate them.

190. Just as with the other gymnasium dormitories, there were obvious security concerns and blind spots throughout the unit. Prisoners have clothing and towels draped down the sides of their bunks in an attempt to create minimal amounts of privacy, but this also means that it is impossible to see what is taking place almost anywhere in the unit. The correctional officer overseeing the dormitory from the raised guard station told me, "we can't see very well from up here. We have to rely on informants" to know what is going on in the unit. He also told me that there are too many people for correctional staff to monitor or be sensitive to: "we have to rely on other

prisoners to tell us that their bunk mate is not handling it well."

[107] 191. In another of the makeshift gymnasium dormitories, a female staff member told me that "the biggest problem is too many people and not enough space. There's a guy in here who has been in 23 years. He has lots of stuff, but where will he keep it? There are blind spots all over here. It is dangerous for staff and prisoners. Triple bunking has made a difference. You just can't see any place. When you go back there [pointing to the far corner of the gym] even the gunman can't see us. It gets really, really hot [in the summer] and the swamp coolers are ineffective."

192. A number of the housing units had makeshift dayroom dormitories in them, with rows of triple bunks where several dozen "extra" prisoners were housed in the unit. Among the many indignities that this kind of housing imposes, prisoners complained that there was only one toilet for some 20 prisoners (located in cells that were set aside to serve as bathrooms for the prisoners on the dayroom bunks). They told me that the line after breakfast was especially long, and prisoners who have to urinate badly or have problems with bladder control have a difficult time managing the wait. Prisoners also explained that, although they are allowed to use the dayroom tables until 9 PM, they are not allowed to be on the dayroom floor after that. Essentially this means that they are confined to their beds from 9 PM until the morning. Not surprisingly, prisoners on the bottom and middle bunks had an especially difficult time with this.

193. A prisoner in one of these makeshift dayroom dorm beds told me that he was a Level IV CCCMS

prisoner who could not handle the stress of this kind of housing: "Because I can't take the pressure I have gone off on people—living in a gym or dayroom, having to deal with all these people—I told them that I was being placed at risk." After living in one of the gym dorms, he was attacked by another prisoner. He told prison officials that "if you put me back in the gym, I'm not going to handle it." In response, he was sent to a triple-bunked dayroom dormitory instead.

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e. California Substance Abuse Treatment Facility (SATF)

(i) SATF Overview

206. I toured SATF on July 28, 2008.

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215. The issues of appropriate space and available staffing came up again and again. The Triage and Treatment Area ("TTA") is outside of the CTC. I was told that prisoners who appear to be in a mental health crisis are first brought to the TTA, where they are put in a treatment cage—referred to here as a "safety cell"—that sits in the corner of the room. The prisoner stays in the cage until a psychiatrist can assess his condition. However, the TTA nurse told me that, when there is no psychiatrist on site, a suicidal prisoner could stay in the cage overnight, with a custody staff member sitting in front of the cage, observing the prisoner throughout.

(iii) Lack of Beds at Appropriate Level of Care

(a) EOP Beds

216. At the SATF orientation we heard about a chronic problem that continues to plague CDCR facilities—EOPs who have been endorsed for transfer to more appropriate programs and levels of care but cannot be moved because of the shortage of bed space. Thus, we were told: "the hubs are always full. We call every week—CMF, Corcoran, Salinas Valley—they are all full. We try to get them out, but there is no room anywhere and it takes months sometime." The Acting Chief Psychologist told us that their program for the EOPs is to have them seen once a week by a case manager, once a month by a psychiatrist, and daily by the psych techs, if they are in Ad Seg. However, they are unable to provide their EOPs with group therapy or other enhanced services during their prolonged stays at the prison. The prison staff acknowledged to us in the morning meeting and during the tour of the prison, that they made no effort to house the EOP prisoners in a single building on a yard in order to enhance the monitoring, safety or clinical care provided to these patients. In fact, we observed EOP prisoners scattered in many yards throughout the prison. As a result of the extended stays at [118] SATF and the limited mental health treatment provided to these EOPs while they waited for transfer, many of them were being admitted to the MHCBs for stabilization, often more than once.[310] In fact, 15 of the 35 EOPs who were at the prison when we toured, had been admitted to the MHCB at least once, and 9 had multiple admissions.[311]

(b) MHCB and DMH Access

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[310] Coleman Pls.' Trial Ex. 100.

[311] *Id.*

217. SATF has a CTC that is licensed for 14 mental health crisis beds that they have expanded to 18, although four of the beds still require retrofitting to ensure that they are safe for suicidal patients. The Chief Psychiatrist noted that all of the beds in the CTC are "flex" beds that can be converted to an MHCB. The staff reported that during a shortage of MHCBs, they are able to send medical patients out to nearby hospitals to open up bed space for mentally ill patients when they are determined to be in crisis. As I noted above, the CTC is "always full." In fact, on the day of our tour, the majority of the MHCBs were filled with patients from *other* prisons, including prisoners from DVI (4), Centinela (2), and CSP-Sacramento (3). Once again, the staff acknowledged that "DMH beds are very, very scarce," and suggested that the wait to transfer typically lasts a minimum of 30 days.

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f. California Correctional Institute (CCI)

(i) CCI Overview

237. I toured and inspected and interviewed staff and prisoners at CCI on July 29, 2008. CCI is located south of Bakersfield, near the Mojave Desert. The Warden reported that the count on the day we were there was 5,625, and this included a total of 1499 prisoners who were on the mental health caseload, 1,402 of whom were 3CMS and 95 EOPs. (The EOP population at the prison appears to have increased significantly this year; during the 20th round [132] of monitoring, as of January 1, 2008, the total number

of EOPs at the prison was 68.)[332] On the CDCR official website, CCI's population was reported as 5,652, or 203 percent of its design capacity of 2,783.[333] CCI has a reception center, a Security Housing Unit (SHU), administrative segregation, Level I and II gym housing, and an unlicensed Outpatient Housing Unit (OHU). The prison staff provided me with documents showing OHU admission data from January 1, 2008 through July 26, 2008, an EOP log for July 29, 2008, a housing report for MHSDS prisoners, an RC EOP transfer log, and a DMH referral log.

(ii) Insufficient Clinical and Custody Staff

238. The high vacancy rates among mental health clinicians at CCI and the use of registry staff to fill these vacancies has been a persistent problem at CCI,[334] apparently the result of very significant and chronic clinical staff recruitment and retention problems. These issues surfaced at the very outset of our tour, and were repeatedly mentioned by administrators and supervisory staff throughout the day. In fact, the problem was so serious that there seemed to be an air of resignation about the problem—"we simply can't get remotely the number of professional people we need to come work here" was the way many of the staff with whom I discussed the issue characterized it. For example, the Chief of Psychology, Dr. Walsh addressed the issue during our orientation meeting with the prison administration this way: "Recruitment and retention? I suppose the word 'nightmare' is appropriate. We do everything we can

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[332] Joint Pls.' Trial Ex. 57.

[333] Joint Pls.' Trial Ex. 60.

[334] Joint Pls.' Trial Ex. 57; Joint Pls.' Trial Ex. 36.

but we just can't get them here." More than half of their allocated psychiatrist positions (5.5 of 8) are filled by contract psychiatrists, and 40% of the psychology positions are open. Also at this initial meeting, Dr. McDill, the reception center Senior Psychologist, indicated that the prison had utilized some 25,000 contractor hours over the last 8 months to service the mental health needs of the prisoner population there. In his words, "that gives you a feel for [133] how much we depend on it." The June 2008 staffing data provided by CDCR to the Coleman Special Master, confirmed CCI's report of their use of significant contractor hours to fill its significant vacancies (28 vacancies, with 21 of them filled by contractors).[335]

239. The Senior Psychiatrist who runs the OHU, Dr. Pouyon, explained that CCI relies so heavily on contract mental health personnel like him for a variety of reasons that make Tehachapi a difficult place to attract and retain professionals—"the weather, terrain, distance from LA—we can't get physicians here."

240. The severe staffing problem was perhaps most acute among the clinicians, but it affected custody staffing levels as well. Some of the severe overcrowding and understaffing issues were addressed later by the Associate Warden who accompanied us during several parts of the tour. He said that CCI was still significantly understaffed, and that "we have put in for 96 additional custody staff so we can do what we need, to deliver the basics properly." In fact, the lack of adequate numbers of custody for mental health and medical escorts came up several times at CCI. For example, the clinicians in the 4A OHU overflow

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[335] Coleman Pls.' Trial Ex. 91, at p. 2.

unit told me that they could not run weekday groups in the treatment cages that they had "because there aren't enough custody staff—there are too many things for them to do—so they have to run the groups on weekends, with whatever clinical staff are there, when the custody staff has less to do.

(iii) Use of Substandard, Non-Traditional Housing

241. The overcrowding crisis has profoundly affected prisoner housing at CCI. At our initial meeting with Warden Gonzalez at CCI, he acknowledged that the facility had "gyms in every yard being used for housing." The makeshift gym dormitories were "deactivated for about a month and a half, but then [population] went back up," so the prison was forced to reactivate them. In addition, there is dayroom housing in the intake area of the prison. All of these overcrowding-related problems were evident as I toured the facility. The institution has been operating at 200% of capacity for a considerable period of time, with no end—or help—[134] in sight. In fact, the Associate Warden noted that despite facing these very serious space shortages, CCI has not yet seen one single "in-fill bed. No ground broken on anything, even though CCI is supposed to be one of the first four facilities" to receive these new beds in the system.

242. As the Warden acknowledged at the outset of our tour, there are a number of prisoners at CCI who are living in non-traditional housing settings, becoming what the Sergeant escorting us for part of our tour at CCI, called "floor sleepers." Many of the "floor sleepers" were in the gym makeshift dormitory that we visited that was being used for Reception Center prisoners. The full count inside the gym was 136 prisoners—the entire room pretty much filled

with open double-bunks on which the prisoners lived. The floor officer, who said he had been there five years "so I pretty much know what's going on," at first indicated that he did not think there were any mental health caseload prisoners housed there. He did not have a list of any kind to readily consult. When we checked the housing report for MHSDS, however, we found that there were 15 CCCMS prisoners dispersed throughout the makeshift dormitory. Conditions inside this housing unit were frankly no better or worse than the others I saw throughout CDCR—open, unsafe, lacking in privacy, and providing the prisoners with little or nothing to do during the day to pass the time.

243. We toured another, slightly larger makeshift gym dormitory that is in use in Housing Unit 4B, where some 142 prisoners are currently confined. The substandard environmental conditions were evident here as well. Here, too, mental health caseload prisoners were housed without custody staff being certain of how many or who, exactly, they were. One of the floor officers indicated that there were "some" 3CMS prisoners currently assigned to this unit and, although there did not appear to be any EOPs there now, they had had them there before. Although this type of housing is intended as short term, for Reception prisoners, the officer indicated that some prisoners have stayed in the gym dorm for six months or more. In addition to the terrible environmental conditions in the unit, it was also apparent that the prisoners really have no programming opportunities. As the officer put it, "they have the dayroom, play games, that's it. And they eat in here." The "dayroom" consists of a series of [135] 14 tables, which also serve as the "dining hall" for the gym residents, and 1 television set in the dorm (used by 140 prisoners). A

prisoner confirmed for me that there was "nothing else to do . . . no program at all." He was resigned to the fact that this was all he would have access to until he paroled from the prison in January, 2009. He said he had been told he would have to stay in this unit for another six months or so "because there are no beds anywhere in the system to put me."

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(v) Inability to Provide Appropriate Levels of Care

251. As has been true for all of the CDCR facilities that I have toured, CCI is plagued by not being able to transfer mentally ill and other special needs prisoners to the appropriate locations elsewhere in the system—the beds the prisoners have been deemed clinically in need of. It is a chronic problem here as elsewhere in the system. Thus, Dr. Eppler, one of the psychologists working in the Reception Center, told me that CCI is forced to hold EOP prisoners who are also SNY for many months, because the only appropriate placement for them—the program at Mule Creek State Prison—does not have any space for them: "We have [139] to keep EOP/SNYs for 6 or 7 months because they can't get transferred to Mule Creek." Obviously, this creates special challenges for the CCI clinical staff. As Eppler put it: "I've got to program them somehow—how can I? They are told they should be moved but they aren't. They don't get what they know they are entitled to—phone, visits, packages, but don't [get these things] because they are awaiting their transfer, waiting for a bed, for 6 or 7 months!" The Special Master was aware of this problem as well, noting during the 20th round of monitoring that "[a]dherence to EOP transfer dead-

lines notably declined during the reporting period."[341] On the MHSDS List for EOPs dated July 29, 2008, showing transfer deadline dates, there are a total of 102 EOPs listed and 46 of them (45%) are beyond the transfer deadline date.[342] The primary reasons provided for the delays are "lack of EOP beds" and "no vacancies at endorsed institutions.[343]

252. In addition to the problem of EOP transfers, CCI suffers from an inability to provide appropriate levels of care at the facility itself. Thus, at the initial orientation meeting, Dr. Alavarez, Senior Psychologist, explained that the OHU currently has 8 beds that are used as MHCBs and another four "flex" beds that can be converted from medical to mental health use. If mental health needs more beds, medical patients are supposed to be transferred to community hospital beds. But the Chief Medical Officer reported to us that the community hospitals were unwilling or unable to accommodate CCI medical transfers so the system did not work as planned. Dr. Pouyon, the OHU director who took us on a tour of the unit, introduced us to Dr. Price, an OHU psychologist who told me he was working to simplify the OHU admission process for mental health patient/prisoners. But he addressed what he thought was a major problem at the CCI OHU: "Our patients are staying too long here—[we're] [140] running this like a CTC, but we don't have a license to function like that—it's not good practice." He elaborated that, in terms of staffing ratios, space, and equipment, and facility infrastruc-

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[341] Joint Pls.' Trial Ex. 57 at 255.

[342] Coleman Pls.' Trial Ex.156.

[343] *Id.* at pages 4-5.

ture, the OHU falls far short of the professional standards it should meet for a CTC operation.

253. The problem of prisoner/patients backing up in the OHU because of a lack of bed space elsewhere—one that was a chronic issue in all of the other prisons I toured—was clearly present at CCI as well. Dr. Pouyon noted that there were "people who we release from OHU status but [who] stay here because we don't have beds." It is also the case that prisoners remain in the OHU for long periods after being accepted for a DMH transfer, where they "languish on a waiting list" for months. Indeed, CCI has several prisoners who have been waiting this way since February, 2008. Dr. Walsh added that "EOP transfers are not pretty. They are staying here longer and longer. We are getting more EOPs coming into the system on parole violations who were EOPs when they left—the lack of bed availability is what is killing us."

254. Another clinician talked about the OHU "overflow" and the fact that they have had to leave mentally ill prisoners in the 4A holding cells for a day or two (and, in the past, it was not uncommon to leave them there for as many as three days). The Special Master noted this use of "alternative sites" during the 20th round when "seven percent of inmates referred to the OHU were placed in 'alternative' holding cells pending admission to OHU beds.[344] Dr. Price described some of the consequences of this back-up, which results in people being kept long-term under conditions that were intended for short-term confinement: "We have people who may stay here for quite a long time—they don't get any yard, no group—they need resocialization. So we have psych

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[344] Joint Plts. Trial Ex. 57 at 255.

techs who come in periodically and read newspapers to them and so on to make sure they don't lose sociability completely."

255. Being kept in such a place for a long period of time, awaiting transfer to a more appropriate facility, would likely affect a person's "sociability" and a great deal more. Indeed, [141] the cells reserved for mentally ill patient/prisoners in the OHU that I saw were barren, desolate, and depressing. In fact, the Special Master reported a "recurring shortage of safety mattresses and suicide smocks" during the 20th round of monitoring at CCI[345] Many of the mentally ill inmates housed in these cells on the day I toured were lying down on the bare floor, with blankets pulled up over their heads.

256. I visited the 4A treatment area located between Housing Units 5 and 6 to see some of the prisoner/patients who were housed there, including two prisoners who had been referred to DMH some six months ago (in February) but had yet to be transferred. In fact, I was told by a senior psychologist who works in this unit, that DMH had actually dropped these two prisoners from their list at the start of July. Thus, he said, both prisoners are now "in limbo," with few alternatives that could be pursued for them. For example, he said, if CCI wanted to send them to the EOP program at SVSP, "they'd be 160th on the list . . . [and] the EOP hub at Lancaster is even harder" to get a prisoner into. He told me that they offered the prisoners as much in the way of EOP services as they could—which amounted to seeing them once a week—"but these guys are needier than that."

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[345] *Id.*

257. Dr. Gendalman, a clinician on the unit, told me that one of the prisoners I wanted to interview, Prisoner WW, was very paranoid and rarely came out of his cell. He will not take his medications and does not appear to be eating. She was aware of an incident I, too, saw reflected in his records in which he had urinated on his food tray. "We regard [this] as gassing, so he had to be in Ad Seg." Yet she felt strongly that "he doesn't appear to be decompensating enough to be referred [because] they wouldn't take him. Bizarre behavior doesn't get you very far up on the list" for DMH transfers. This prisoner appears on the CCI DMH referral log provided to me on the day of the tour as accepted to ASH APP on February 29, 2008 and remains on the waitlist.[346]

[142] 258. When I went to Prisoner WW's cell to speak with him, he appeared very frail and very afraid. He told me he saw his clinician once or so a week and agreed that she was helpful. But he told me that he does not like to come out of his cell or be around people at all. He said, "I don't like groups. I only go to yard by myself," and repeated that he was too afraid to come out of his cell. Indeed, even as he spoke to me, his eyes were darting around and he was nervously looking behind me to the tier, to see who was out there and what was happening. He told me that he is very afraid of being placed on EOP because he is sure that it would result in his transfer to another prison where he would be killed. Prisoner WW told me that he gets out of prison on November 23rd of this month but that he feels he doesn't need any more help. "I'll be OK," he told me.

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[346] Coleman Pls.' Trial Ex.157.

259. I saw Prisoner XX one of the Building 5 prisoners who had been awaiting DMH transfer for many months. He was brought out to one of the treatment cages in the hallway outside the unit, where I interviewed him. He was so floridly psychotic that it was almost impossible to converse with him. In the midst of his disorientation, he did manage to tell me: "Prison is a certain level of suffering. I don't know why people want to torture one another." Prisoner XX did manage to tell me that he had been in prison for about 14 years, including some time spent at Patton State Hospital, where he said he had been "many times." His mind wandered throughout our interview. He was often unable to respond cogently and he could not remember exactly when he had last seen his clinician. He told me he was currently taking Resperidol and he thought that it helped him. Prisoner XX said: "I've been told that I should be going somewhere else, but I don't know where or when. I can't predict the future." He also is listed on the DMH Referral list as accepted to APP on February 8, 2008, but currently on the waitlist.[347]

260. The last prisoner I interviewed, Prisoner YY was also seen in one of the treatment cages in the hallway outside 4A. He told me he had been diagnosed with bi-polar and [143] obsessive compulsive disorders, and that he continued to see and hear things that others did not. He said that when he is in close confinement he "can't take it, the walls close in on me." Prisoner YY said that he was once taking a variety of psychotropic medications simultaneously, including Remeron, Zoloft, Depakote, and Geodon, and that, because of the serious side effects they

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[347] Coleman Pls.' Trial Ex.157.

produced, he now takes only Geodon. He said that he first came into the prison system in 1999, at age 17, to serve a sentence of life with parole. At that time, he said, he was guarded about what he perceived to be his "mental health problems" because he did not want "to let people take advantage of it." But his problems worsened by the time he got to CCI and he began to have visual hallucinations and to hear voices. "They took me to the infirmary, to a bare cell, on the floor, where you sleep. It didn't help me." Prisoner YY was placed on the EOP caseload in November, 2007, but was taken off a few months ago. Although he said he still hears the voices all the time, he is getting very little treatment at CCI. There is "no helping, no groups—not any help at all . . . I have no program at all, since April. We haven't even been to yard. I just stay in my cell and watch the walls close in on me." He appeared to be doing poorly at 3CMS level of care. Staff later confirmed that this unit has been on complete lockdown (no yard whatsoever) since April 3, 2008, when several staff members were the victims of a serious attack by two prisoners.

(vi) Lack of Adequate Programming in ASU and SHU

261. The lack of adequate programming and treatment in the segregation units at CCI was apparent from the last several interviews described above. In addition, the Special Master observed that "limited program space [in the administrative segregation units at CCI] often forced clinicians to interview inmates in non-confidential settings."[348] Very severely mentally ill prisoners are being housed under extremely harsh conditions with very little out-

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[348] Joint Pls.' Trial Ex. 57 at 256.

of-cell time or meaningful treatment being provided to them. Some of them appear to be so ill that they cannot utilize even the limited clinical contact they are afforded. I have reviewed documents [144] indicating that there were two suicides in the CCI SHU in 2007. There was another suicide in the Ad Seg unit in March 2008 not long before we toured the prison.[349] Remarkably, however, no one with whom we discussed the problem of suicides at the institution saw fit to inform us that another suicide had taken place just a few days before our visit.[350]

262. There were additional overcrowding-related problems with mental health programming at CCI. The prison is one of several CDCR facilities that house a Security Housing Unit (SHU), where prisoners are placed for having been found guilty of what the Department regards as the most serious disciplinary infractions. We toured one of these units, 4B, Housing Unit 5, B section. As we walked toward the unit from the outside, we passed by small exercise cages—so-called "individual exercise modules"—where a number of prisoners were outside under the midday sun. Prisoners in the SHU here can be double celled "if they are compatible," and many of them do live this way. In the SHU at CCI, mentally ill prisoners are not separated from everyone else, and they are not concentrated in one area of the unit. The unit I toured was an "old style" SHU that appeared to predate even the Pelican Bay model. One of the COs in the SHU told me that he had two suicides in his housing unit in just one week last year (December,

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[349] Coleman Pls.' Trial Ex. 83, Coleman Pls. Trial Ex. 85.

[350] Coleman Pls.' Trial Ex. 85.

2007). He did not know whether either of them was on the mental health caseload.

263. I interviewed a SHU prisoner, Prisoner ZZ in a treatment cage just outside the housing unit. He told me that he had been in prison most of his life—only five years spent on the street since 1970. Prisoner ZZ had been in the SHU at Pelican Bay three different times over this period and came to the CCI SHU about four and a half years ago. This is where he decided to "de-brief," and relinquish his prior gang affiliation. He explained that he was placed on 3CMS status at CCI about three years ago and he was hoping that the debriefing process would be finished by now. In fact, he turned in his "autobiography" some 30 months ago and [145] has become very concerned that he has not been transferred to another facility. The stress of the long wait and the uncertainty about his fate has made his psychological condition much worse: "I'm under a lot of stress now—things are stacking up on me. I was asking repeatedly to see a psychiatrist—it took two weeks before he came to see me. Prisoner ZZ is an active participant in a group that is held in the treatment cages—he and two other prisoners participate in a "how to survive the SHU" group together, which he finds beneficial. But the mental health contact is far too limited. He complained that he received only one group per week, and had only one regular psych tech contact per week, but he added that "they don't really do anything." He reported that the frequency of psych tech rounding was cut back a year ago from daily rounding to a psych tech round only once a week.

264. A second SHU prisoner, Prisoner AAA, appeared to be significantly impaired. He told me that he had been in the CDCR for 12 years, serving a

sentence of 385 years to life. Although he was on 3CMS status early in his prison term, he is now on EOP status. Prisoner AAA has had one brief stint in Patton State Hospital, which occurred in 1996, when he was committed there for 72 hours from the streets. He said that he has moved from prison to prison for the last 12 years. Prisoner AAA is both hearing and visually impaired, a member of the *Clark* class of developmentally disabled prisoners, and is an EOP prisoner. He told me that he has been hearing voices since he was a teenager, and has taken a number of anti-psychotic medications (including Thorazine and Haldol). He understands that he may represent a threat to others: "When I get upset, I want to hurt people who are bugging me. I've had lots of problems with cellies." He has also attempted suicide on a number of occasions. He told me: "I'm psychotic. They make you psychotic in here." Prisoner AAA was concerned over the level of care he was being provided at CCI. He told me: "I kept telling them I wasn't getting any help. As 3CMS you get nothing. I've had two groups—they both ended when the clinician left, after I opened up to her. [We had] only a couple of sessions, but it stopped." He told me that the psych techs visit the prisoners on the caseload only once a week, "to give you a puzzle." He told me that he had been made an EOP three or four months ago and has been awaiting a transfer ever since. Prisoner AAA was referred for EOP transfer on March 20, [146] 2008, but has remained at CCI well beyond the 60 day transfer timeline because of a "lack of beds."[351] Prisoner AAA said that the EOP program at CCI does not differ much from the minimal program he had been getting as a 3CMS, except that he gets group once a week, when they bring him out to one of the cages. But he also said that the COs are always rushing his clinician, asking her if she is finished yet.

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[351] Coleman Pls.' Trial Ex.156.

g. North Kern State Prison (NKSP)

(i) NKSP Overview

265. I toured and inspected and interviewed staff and prisoners at NKSP on July 31, 2008. According to CDCR data, the facility was operating at 200% capacity on July 30, 2008, with 5,404 prisoners confined in a prison designed for 2,694.[352] Staff reported to us during the tour that the prisoner census on that day was 5,381 prisoners. They also reported that there were 917 3CMS, 66 EOP and 10 MHCB patients in their census. NKSP has a large reception center population spread over four yards. Yard A has five 270 housing units, with two for general population, one gym and three for reception center prisoners. Yard B has six "wingnut" units all for reception center prisoners. Yard C has four "wingnut" units and two dorms, all for reception center prisoners. Yard D has six wingnut units, five for reception center and one for Ad. Seg. Yard E is a minimum security facility. A Yard also has a makeshift OHU in building 4, which is a mixed housing unit of RC Ad Seg Overflow and the OHU. The prison is located approximately four miles north of Kern Valley State Prison and is an exact replica of a neighboring prison, Wasco State Prison.[353]

(ii) Shortages of Space for Offices and Treatment

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[352] Joint Pls.' Trial Ex. 59.

[353] Coleman Pls.' Trial Ex. 104.

266. At the initial orientation meeting, the prison staff provided me with a log of all MHCB admissions for May-July 2008, a NKSP EOP transfer log, a list of all NKSP MHSDS prisoners, and a log of Mental Health Temporary Housing with lengths of stay and re-housing locations. Warden Hense began the meeting by acknowledging that the North Kern facility was not built with any real programming or treatment space, yet is now required to provide it. She noted that they recently created a temporary "OHU" by modifying a number of cells, but the unit is unlicensed and they did not get any additional staffing allocations associated with the OHU beds. So, as she said, 'it's not an actual OHU." However, because of the reported waitlist of six to ten days for an MHCB, the staff reported that the OHU is regularly used for prisoners waiting for a crisis bed.

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(vii) Lack of Beds at Appropriate Level of Care and Delays in Transfers

293. From the very start of our tour at North Kern—from the morning orientation meeting and for much of the rest of the day—we heard about the crisis bed shortages at the [160] facility. Chief Psychologist, Dr. Hirakawa told us that the North Kern gets about 100 new prisoners each day, and that nowadays it seems many more of them are coming into prison who need crisis beds. But the crisis beds simply are not available. On any particular day, he said, "we have a census of 6-10 people *waiting* for a crisis bed . . . We had to become creative. [You'll] see EOPs, and CCCMSs, Ad Segs in hallways. The

reality is that we have no place to see patients. It's a serious problem."

294. In this regard, I toured the CTC trailer at North Kern. It has holding cells in the front that are used for prisoners with special needs, and overflow from the CTC itself. The cells are not suicide proof. The North Kern CTC has 10 licensed MHCBs. Although there were exactly 10 prisoners in the crisis beds on the day we visited, Dr. Schmidt, a psychologist who works in the unit, told me that "I've been here for 10 years. This is the second time I've seen no one in our overflow." He went on to tell me that it was a "big problem" to house the CTC overflow "all the way over in A4," because it limited staff access to them.

295. This general issue—the lack of beds at the appropriate level of care at North Kern—was underscored and illustrated in some of the interviews I conducted with prisoners. For example, while in the D-4 housing unit, I interviewed Prisoner HHH. Prisoner HHH told me: "I need help. I'm 3CMS, have been since 1998, diagnosed as a paranoid schizophrenic." He said that he had been sent to Patton State Hospital in the past, and had two prior suicide attempts. He also was in an outpatient mental health program the last time he was on the streets. Prisoner HHH was returned to CDCR about a year ago and has requested EOP level of care to address increased mental health symptoms. However, the request has been refused. He is currently taking Geodon, although he has taken Remeron, Zoloft, and Seroquel in the past. Prisoner HHH went on to explain that the staff at North Kern "tried to put me in dorms" but that he "got suicidal—I hated it." He is especially concerned about being sent to a dormitory at Corcoran State

Prison, which he believes is what is in store for him. But, because he is SNY, he does not want to go there. In fact, he says, he very much wants to participate in groups, to receive some form of counseling or treatment, but feels he is getting nothing but medication here. Because he gets out of prison in November, 2009, he says, "I want to get the help I need." [161] But it does not appear to be available at North Kern. He indicated that he is still hearing voices, gets paranoid, and "I worry that people are out to get me." Yet, even after he has requested help and explained his problems, "still nothing happens." His "program" at North Kern, as he described it to me, is that, in addition to twice weekly dayroom: "I stay in the cell all the time, except for yard. I go a couple of times a week. That, and TV, and showers, is it."

296. North Kern has also found it impossible to meet EOP transfer deadlines. At the general orientation meeting, staff informed us that they continued to be concerned about the length of time that EOP prisoners were staying at their facility, one that they conceded was not designed to house EOPs on a long-term basis. The mental health staff indicated that the problem was not so much getting the EOPs endorsed for placement elsewhere but rather finding the beds once they were endorsed. The Warden also acknowledged that "we have a lot of them, and it's hard to place [these] inmates." In fact, the prison's own data indicate that 25 of the 66 EOP prisoners (or 38%) at NKSP on July 29, 2008 were there beyond the *Coleman* transfer timelines.[364] More problematic, however, was the fact, that EOPs represented

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[364] Coleman Pls.' Trial Ex. 159.

21 percent of the admissions to the MHCB between May and July 2008, although they are only a small percentage of the overall MHSDS population (on July 29, 2008, only 7 percent of the overall MHSDS).[365] It seems that EOP prisoners who are housed at NKSP without EOP level of care do not fair well. The Special Master found that NKSP's failure to transfer their EOP prisoners in a timely fashion was not due to institutional delays, but rather "attributed to lack of beds around the state."[366]

297. In addition to problems transferring EOPs, the Special Master found that "[a]ccess to DMH acute care was inadequate over the monitoring period."[367] Indeed, Dr. [162] Hirakawa told me something that was echoed everywhere I went, namely that "DMH transfers are a real problem. Unless your guy is suicidal, you can't get him in. [He] sits on the waiting list." Dr. Pitts agreed, saying that the backlog for transfer of gravely disabled prisoners was "a real problem. Our gravely disabled patients stay 90 days or so often in the CTC." Dr. Hirakawa said that they have found it very difficult to find any crisis beds elsewhere in the state, and that it is rare for their CTC to have an empty bed: "We often have 10 or even 15, which means we need to go elsewhere."

298. At the CTC, Dr. Schmidt noted that their DMH referrals "used to languish here for 45-60 days," and that this had "gotten somewhat better in recent months." But the referrals were still staying too long—he could not estimate how long—and if they were not suicidal they still "languish a very long

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[365] Coleman Pls.' Trial Ex. 159, Coleman Pls.' Trial Ex. 160.

[366] Joint Pls.' Trial Ex. 57 at 238.

[367] *Id.* at 237.

time." Staff told us about one patient in the CTC who had been in the unit for a month since he had been referred and accepted in DMH on June 23, 2008, 38 days ago. He was currently number 16 on the DMH waitlist for an acute bed. There were several other patients in the unit who had either been referred to DMH or had extended stays and were being evaluated for an acute referral. Dr. Schmidt noted that "when we put people on the DMH referral list for grave disability, they just don't go, even if they are profoundly disabled or dangerous."

h. Wasco State Prison (WSP)

(i) WSP Overview

299. I toured and inspected and interviewed staff and prisoners at Wasco State Prison on August 1, 2008. The prison staff provided me with charts and data reporting the MHSDS census, the crisis bed census, EOP transfer data including delay factors, and DMH referrals and transfers. On July 30, 2008, the prison population was reported as 5,938, or 199% of its design capacity of 2,984.[368] The prison staff reported to us that the mental health population on July 29, 2008 was 1117 3CMS and 105 EOP and 6 MHCB patients. Wasco's physical plant is [163] similar to NKSP, with reception center housing on Yards A-D, in a mix of celled and dorm settings. General population prisoners are housed on Yard A and the Ad Seg is located on Yard D. Yard E is a minimum security facility. In addition to the CTC which has 6 designated MHCBs, the clinical staff reported the existence of overflow crisis beds in B-2, B-6 and D-6.

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[368] Joint Pls.' Trial Ex. 59.

300. Wasco is faced with a number of serious overcrowding-related problems. As we were leaving the Administration Building, the Chief Medical Officer (CMO), Dr. Michael Songer told me that "we are coming apart at the seems. We don't have enough space to put people, don't have enough space to see them. Plus, we can't hire psychiatrists. We just can't. We can hire psychologists but not psychiatrists. It's a big problem." These serious overcrowding-related issues—lack of clinical staff (in particular, psychiatrists), lack of treatment and programming space, and far too many prisoners—jointly undermine the treatment of *Coleman* class members at this facility.

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(iv) Lack of Beds at Appropriate Level of Care and Transfer Delays

306. I toured one of the Reception Center housing units, B-2(B). One of the floor officers in the unit, explained that this unit housed "a little bit of everything, including EOPs, SNYs, *Armstrong* class members, DDPs, and Suicide Watch overflows." There were 13 men living in makeshift triple and double bunks, set out on the dayroom floor, directly in front of the unit television on the wall. He acknowledged that EOP prisoners could be housed in these open bunks, depending on their circumstances—"I have done it lots of times." As I found was true of most of the units in the various prisons I toured, however, the officer did not know offhand how many EOPs he presently had in his unit, and he was not at all certain of exactly who any of them were: "We don't have an open list and I don't know." He indicated that a number of groups were held in the housing unit.

However, they were conducted at the fixed [166] metal tables on the dayroom floor, ones that he said were open to everyone in the unit, regardless of their mental health status.

307. I asked the Unit Sergeant about the suicide watch cells in the unit. He told me: "I don't think it is a good idea to have suicide watch cells in here. This is not set up for it. But the prison wrote the procedure and we have to follow it. On a bad day, we have had as many as ten suicide watch inmates here; we've had them for several days at a time. After three or four days, they take them to CTC." Dr. Newton added at this juncture that: "We are in desperate need of more CTC beds. This suicide watch procedure is dangerous. It's only a matter of time before someone kills [him]self."

308. Wasco officials indicated that they regularly contact the Health Care Placement Unit in Sacramento for assistance in placing prisoners in a mental health crisis bed when their CTC is full. For example in April 2008, the prison referred eight prisoners for MHCB placement because their MHCBs were full. However, none of these referred patients were transferred.[369] The four EOPs who were referred for MHCB placement were eventually returned to their housing unit after waits of up to seven days.[370] Similarly, in May 2008, the prison referred seven EOP and one 3CMS prisoner for MHCB placement system-wide, but none were transferred.[371] Four of the EOPs were eventually admitted to the crisis unit

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[369] Coleman Pls.' Trial Ex. 133.

[370] *Id*

[371] Coleman Pls.' Trial Ex. 134.

at Wasco.[372] In June 2008, it appears that neither of the EOPs referred to HCPU were transferred to an MHCB system-wide during their waits of 9 and 19 days before they were admitted to the [167] NKSP MHCB.[373] The CTC Overflow table provided to me on the day of my site inspection lists 18 prisoners, including 13 EOPs, with lengths of stay ranging from 2 to 24 days.[374]

309. The Special Master confirmed that the use of holding cells pending MHCB admission was problematic at Wasco: "Lengths of stay often exceeded four hours . . . [a]lternative holding cells were utilized frequently, and for prolonged periods of time in many different settings throughout the institution. There was no indication that the CTC was used as the priority setting. Documentation revealed suicide watches conducted in the CTC, holding cells, administrative segregation, and R & R. Records showed at least 134 uses of alternative cell placement in a six-month period, including several prisoners with multiple admissions. One quarter of the prisoners in the alternative settings were held on suicide watch for three to nine days."[375]

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313. We encountered one particular tragic case as we passed through the Wasco CTC. I saw a prisoner lying down in one of the cells near the entrance to the unit. We were told that he had been in the CTC for a

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[372] *Id.*

[373] Coleman Pls.' Trial Ex. 135.

[374] Coleman Pls.' Trial Ex. 161.

[375] Joint Pls.' Trial Ex. 57 at 217.

very long time. I asked to interview him. Inmate III was brought to an area in the CTC that is used for IDTT and that doubles as clinician office space, and talked with me. Mr. III, is a 49 year-old prisoner who has had one leg amputated just below his knee (the result of being shot by prison staff at Tehachapi) and he requires a wheelchair for mobility. He confirmed that he had come to the CTC at Wasco approximately 102 days ago. He told me that he was picked up on the streets for soliciting a prostitute and, because the prospect of returning to prison for a parole violation was so overwhelming, he attempted suicide by slashing his wrists and throat. By all accounts, it was a very serious [169] suicide attempt. After a few days of hospitalization, Mr. III was transported to Wasco as a parole violator.

314. The severity of his suicide attempt resulted in his immediate placement in the CTC, some 102 days ago. Although obviously in need of a higher level of care than could be provided in the CTC, Mr. III was held there in part because he had "appealed his parole violation" (and DMH would not consider him for transfer until that issue had been resolved). However, his hearing date was postponed because the Wasco clinical staff had determined that Mr. III's precarious mental health status required that a nurse accompany him on the trip to Fresno (where his parole violation hearing was to be held). Unfortunately, the prison lacked any available staff for this purpose. Because his hearing was delayed, his transfer to DMH or another more appropriate facility was postponed indefinitely and he remained in his MHCB cell in the CTC. I later learned that the hearing was apparently held on July 18th, and Mr. III's transfer is now imminent.

315. The conditions of Inmate III's confinement during this 102-day waiting period were abysmal. The MHCBs lack furniture so, for more than three months, Inmate III lived his life—slept, ate, and otherwise just sat—literally on the floor of his barren cell. In addition to his amputation, Inmate III indicated that he has four artificial disks in his spine, so that being forced to live on the floor was physically very painful as well as degrading. As he put it, "I'm a wreck, physically and mentally." He told me that about three weeks ago a correctional officer took pity on him and provided him with a thin mattress to sleep on; he asked for a pillow too but this request was denied. During his hundred days in MHCB, Inmate III was clothed for this time in a standard smock and was required to eat from a paper plate, without any utensils, even plastic ones. He told me that he tore off a piece of the paper plate to use as a makeshift spoon because he did not want to be forced to eat with his hands. Because his amputation made it impossible for him to walk, he was forced to "scuttle" when he wanted to move around in his cell and he showed me the calluses on his knees from this practice.

316. Other than routine cell front check-ups from mental health staff, and an occasional visit from the recreational therapist who comes by the unit to see all of the patients [170] there, Inmate III received no regular individual or group therapy while he was confined in the CTC. He said that he had never been taken out of his cell for mental health treatment of any kind; the staff "tell me that's not their job—just [do it] through the door." Because of his MHCB status, he also could not have social visits from outside the prison or receive canteen. A brief review of Inmate

II's records in the CTC confirmed the basic facts that he relayed to me.

(v) Reception Center Problems

317. Wasco State Prison serves as one of the Reception Centers for intake into the CDCR for prisoners from a number of areas in Southern California. I toured the Receiving and Reception ("R & R") area of the prison, which is laid out virtually identically to the North Kern facility visited the day before. However, I was told that the Wasco R & R receives a larger percentage of parole violators compared to North Kern. I talked to a contract psychiatrist, Dr. Christina Golden, who was assigned to R & R at Wasco. She told me that she shared office space on the unit with a nurse, so typically tried to conduct more or less confidential psychiatric evaluations with prisoners by sitting outside the bars of the large holding cells where they were kept. She was very candid about the consequences of overcrowding and the lack of appropriate bed space at the prison, in particular at the CTC: "We do the best we can, but we put people in overflow all the time. We're desperate for beds."

318. In her view, the situation certainly had not improved recently: "In the last two weeks, custody has been pulling its hair out because they do not have beds anywhere." Dr. Golden was equally candid about the challenges faced by clinicians who are doing screening in the R & R: "We don't really catch all the people who need 3CMS and EOP that come in—the psych screening is so brief. I don't really have records. [I] never have them before I see [a prisoner]. I've never seen a doctor's note or history on the courts' record—never—I just have a medication record—the rest is my clinical judgment."

319. Dr. Golden also told me about a prisoner, Inmate JJJ, who entered the facility the day before, and whose case she thought illustrated some of these problems. Inmate JJJ had come in the day before acting strangely and was identified by custody staff as needing immediate psychiatric attention. She interviewed him, without any paperwork that might have [171] indicated his medication needs or prior mental health history. She immediately determined that he needed to be put on suicide watch in an appropriate MHCB. However, she also knew that this might be difficult to arrange. He was moved to a "dry cell," on the floor of the R &R unit, to await transfer to an MHCB. However, instead of being moved to an MHCB that day, where they could care for him, as he should have been, she said, Inmate JJJ remained in the holding cell in the R & R today. She told me, with much concern: "I just saw him. He shouldn't be here. A custody person has had to watch him." Then she added: "We are struggling here, trying to provide decent psychiatric care in a place like this, but it is really hard."

320. When I went to look for Inmate JJJ, I found that he was being kept in a separate cell off the main rotunda area of R & R. There was blanket on the floor, but no bunk, mattress, toilet, or sink in the cell. Inmate JJJ was standing straight up in the middle of the cell, almost at attention, dressed in a suicide gown; he had urinated on the floor. A nurse's assistant, who was sitting outside his cell, holding suicide watch, confirmed that he had been like this for quite a while. Inmate JJJ had a fixed gaze and he would not make eye contact. He appeared to be completely unresponsive, virtually catatonic. The nurse told that he had been standing more or less motionless for hours and that, in fact, he had been in exactly this state when

she had left him the day before: "his behavior hasn't changed." He clearly had not eaten—the food tray that sat on the bench behind him did not appear to have been touched. As I was trying (unsuccessfully) to talk with Inmate JJJ, and asking the nurse about his case, the mental health staff members who handle the CTC overflow showed up for the first time. When they arrived, Dr. Newton indicated to me that the "overflow staff should have been in to see him last night." The psychiatrist explained that, unfortunately, they currently had "no place to put him; we'll have to move someone" in order to make room for him.

321. When I discussed Inmate JJJ's case with the Lieutenant, who oversees R & R, he acknowledged the serious challenges his staff regularly faces in R & R. For one, he told me, they do not often have much information about individual incoming prisoners when they come off the bus. "When parole violators come in, there is no information with them. [The paperwork] says, 'parole hold,' with a picture of the guy and where he's from." So the prison [172] staff has to do their mental health and other assessments essentially from scratch in most cases. In Inmate JJJ's case, the Lieutenant recalled that "he was basically catatonic when he came in." We determined from examining the unit logs that Inmate JJJ had been processed in at 1330 hours the day before. Thus, he remained in a catatonic state, standing in a bare holding cell, awaiting a transfer to an MHCB, for nearly 24 hours. He was still there when we left the unit.

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3. General Observations About the Impact of Overcrowding in These Facilities

332. Below I summarize some of the numerous overcrowding-related problems that I encountered on these tours and interviews, ones that I either saw directly, heard staff members describe, or about which prisoners repeatedly and consistently complained.

a. Backlogs Due to Overcrowding

333. There are troublesome and potentially dangerous backlogs at virtually every critical juncture in the mental health delivery system, whether they involve the flow of critical information (such as the forwarding of medical and mental health records), delays in the time it takes to make appropriate referrals and to transfer prisoners to their proper destinations (where they would receive badly needed care and treatment), or the speed at which mentally ill prisoners are removed from inappropriate housing and units (whether they are Ad Seg, "bad beds," or holding cages). For example, a correctional counselor at CIM told me candidly that "the transfer process is not working as well as it should" and estimated that it was taking as [178] many as 120 days for EOPs to move through the classification process and be sent to their proper destination. Other professional staff told me that they have "had EOPs in Ad Seg on my caseload for months. I know I'm not supposed to but I do." The same person later told me that "I've had EOP guys in Ad Seg for 6 months or more."

334. These comments and my observations are representative of a system in overall crisis, one that cannot meet the court-mandated and agreed upon mental health transfer timelines. For example, in CDCR's monthly summary of mental health crisis

bed referrals and transfers from the Chief of the Health Care Placement Oversight Program, Rick Johnson,[381] for June 2008, there were a total of 355 MHCB referrals of which only 52 were actually placed. A large number (303, or 85%) of referrals were "rescinded" by the referring clinician before Health Care Placement Oversight Program staff could locate an empty mental health crisis bed within CDCR. Approximately one-third of those rescinded were ultimately placed in a crisis bed at the prison where they were housed. However, over a third of the prisoners referred to an MHCB (114/303) waited an average of more than a week (8.46 days) before their referral was rescinded.[382] Those 52 prisoner/patients who were successfully transferred to an MHCB in another prison spent an average of nearly 10 days (9.33) awaiting transfer; with 40 days as the outer range for days waiting to transfer. Only 5 prisoners, less than 2% of those referred, were transferred to an MHCB within the required 24 hours.[383]

b. Staff Shortages

335. Every facility I visited suffered significant staff shortages of some kind—ranging from significant shortages of custody staff to a drastic shortage of psychologists, to the overuse of contract psychiatrists. In various ways, serious staffing shortages all translate into inadequacies in the mental health delivery system and, in some instances, an outright denial of [179] needed and mandated mental health services. In many of the units this means that professional

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[381] Coleman Pls.' Trial Ex. 135.

[382] *Id*. at 8.

[383] *Id* at 2.

staff are doubling up on duties, performing more tasks than they should be called upon to handle, and managing far larger caseloads than is appropriate or effective. One psychologist at CIM told me "I can't keep up with everything. I've been doing too much. We hired new staff, but that hasn't helped." He also told me "in my opinion, we are doing about 50% of what we should be doing."

336. The CDCR June 2008 system-wide staffing data corroborates what I saw and heard at the individual prisons I toured. With 440 mental health vacancies system-wide, representing 24% of the overall positions, more than 206 psychologist and 88 psychiatrist positions were vacant in June 2008.[384] A total of 80 of the psychologist and 38 of the psychiatrist vacancies were covered by registry, leaving significant missing staff in these critical positions.[385] Of perhaps greater concern is the revelation in the Special Master's review of the long-awaited workload study that CDCR's 2008-09 staffing requests (based on the workload study numbers) significantly *underestimated* the staffing needed to implement critical portions of the *Coleman* Program Guide requirements (for example, the EOP Ad Seg program, the RC EOP program, the RC EOP pre-release planning component and so on).[386] Furthermore, key tasks were omitted when determining staffing workloads, including central file reviews, frequency of case manager contacts, psychiatric review of the medical records and so on. Finally, there were concerns expressed about key assumptions provided to the researchers upon which

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[384] Coleman Pls.' Trial Ex. 91.

[385] *Id.*

[386] Coleman Pls.' Trial Ex. 64.

they based their calculations (including, for example, that only 30 percent of the 3CMS population were taking medication, although the actual percentage is approximately 80 percent.).[387] CDCR has now been tasked with revising the workload study [180] calculations with the Special Master's critique in mind, to conduct reviews of the staffing needs twice a year, and to involve the *Coleman* experts in the process. Once the more accurate staffing needs have been calculated that provide for the implementation of the *Coleman* Program Guide, a more valid staffing augmentation can be determined for each prison, along with a calculation of the additional treatment and office space that will be needed to accommodate the much expanded clinical teams. In short, however, the actual clinical and custody staffing necessary to provide the mental health care required by the *Coleman* Program Guide is significantly greater than the existing budgeted levels; yet defendants have been unable to recruit and retain staff even to meet the budgeted levels. In my opinion, the serious deficiencies in office and treatment spaces I observed throughout the system are themselves an obstacle to ever achieving appropriate clinical staffing. The working conditions are terrible and there is no space, in any event, for more clinicians.

c. Space Shortages

337. Although the specific kinds of staff shortages varied from place to place, and some facilities reported having nearly all of their budgeted positions filled (at least in one or another clinical category), shortages in space were widespread, generic, and severe. Each one of the facilities I toured was short of

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[387] *Id.*

significant amounts of space needed to perform otherwise critical tasks and responsibilities. The shortages of offices were perhaps most obvious at (but certainly not restricted to) those facilities fortunate enough to have even near their allotted number of filled staff positions. And *every* prison had inadequate space in which to conduct treatment. In some units, prisoners had to be transported to other parts of the prison for treatment—a time consuming and custody-staff intensive practice—because, as clinician after clinician told me, "we don't have any program space here at all." Even in facilities that had added new clinical staff to handle the mental health caseloads, space was at a premium. For example, the chief psychologist at VSPW told me that they expected their newly hired staff to increase the number of groups they could offer and reduce the long waiting lists but, "as far as space, we are literally crawling all over each other . . . We've been going through the prison inch by inch, looking at storage rooms, anything that is possible to use for mental health [181] space." Indeed, clinicians and mental health clerical staff were literally operating out of converted visiting rooms, closets, and storage rooms. Storage spaces, benches sitting out in the middle of open dayroom floors, and chapels were being used as clinical "treatment" areas. Another clinician told me, "we don't have space to have the confidential contacts we need," and that fact was clearly and repeatedly evident in every facility I toured. These kinds of complaints were echoed again and again by staff members at every prison I visited.

338.In many of the units I toured, the critical shortage of treatment space meant that prisoners were forced to draw unwanted, embarrassing, and potentially problematic attention to their mental health status, as they were taken out of their cells or from their housing units, sometimes to participate in group or individual counseling in full view of the rest of the prisoners on the unit. As one mental health staff member told me, many of the groups were being underutilized because "prisoners don't like the stigma."

d. Lack of Meaningful Activity and Treatment

339. Idleness has increased at all of the prisons, presumably due to overcrowding and the fact that there are too few programming activities, jobs, escorts, and treatment opportunities for the number of prisoners at each prison. In some VSPW units, for example, women told me that they used to get out of their cells twice a day for programming, but that has now been cut to just once per day. Everywhere I went in the prisons I visited, most of the prisoners were in their cells during most of the day I was at the prison. The one exception to this was Mule Creek, where several of the large outdoor yards were being put to good use. But even there, prisoners complained widely about the lack of adequate programs (as opposed to recreation) and the content of the programs they were provided. And, in any event, the prisoners at the other facilities did not fare nearly as well. In literally every prison I visited, large numbers of prisoners, many of whom were on the mental health caseload, were sitting or milling about, with no programs or activities in which to participate. This was most striking in the makeshift dorm or dayroom housing units—or the bizarre "caged-in" dayroom dorms at CIM—where a hundred men or women at a time were sitting atop or standing around their double or triple [182] bunks. But it was true of the celled housing units as well, where there was

typically little or no inmate movement or meaningful activity in progress.

340. And the enforced idleness is even more profound—almost total—for the mentally ill prisoners who have been placed in the Ad Seg and SHU units. One CIM prisoner's comment was typical of what I saw and heard. He told me: "I just lay on my bunk all day long. That's all I do. I have group on Wednesday and Fridays—about how not to be depressed. Nobody else goes. You have to sit in a cage, with your handcuffs on. But I go for something to do. I am the only member of my 'group' sitting there in the cage." The numbers of such *Coleman* class members living under these severe conditions is substantial and periods of time that they spend there quite substantial. For example, the Health Care Placement Unit Information Report (dated June 20, 2008) shows that at SATF alone there are approximately 50 CCCMS prisoners who have been housed in Ad Seg for more than 200 days, several for over 1000 days.[388]

341. In addition, the content of the therapy groups I observed or learned about in many of the units was frankly questionable. Many of the groups appeared to serve little more purpose than to get the prisoners out of their cells (not an insignificant goal, but hardly psychotherapy for seriously mentally ill prisoners). Thus, I watched two Ad Seg EOP prisoners at CIM stand side-by-side in their treatment cages for "group"—which consisted of watching the film "Mission Impossible." At another prison, *Coleman* class members told me they had recently watched "The Mummy" in one of the "group therapy" sessions. In fact, numerous prisoners told me that their groups

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[388] Coleman Pls. Trial Ex. 57 at R10-14, R10-15.

consisted of little more than watching movies, and that they participated largely because this was one of the only ways that they could get out of their cells, however briefly and infrequently.

342. Indeed, many of the prisoners I interviewed complained about the lack of real treatment at the prisons where they were housed. Although some said that they were getting [183] contacts with the clinical staff (a number did not), they nonetheless felt that little was being done to truly help them with their mental health problems. In addition, however, a uniformly expressed complaint on the part of prisoners who were nearing release dates was that they had been given little or no preparation for their return to free society. One told me, "it's difficult to come into prison to begin with. But my mind has been off, and I haven't been thinking about reality, and still I got no real help here. So I'm trying to help myself, and I am proud of myself for doing that."

343. Numerous prisoners complained about waiting to be transferred out of the reception center or waiting to go to another more appropriate program than they had been cleared for, and never being told why they were forced to continue to wait or when they would get the help they needed. And a very large number voiced complaints about their medication—for example; being abruptly taken off medication that they felt was effective, or being given heavy doses of medication that had such adverse effects that they stopped taking it.

e. Use of Holding Cages

344. The use of holding cages is rampant throughout the CDCR. Prisoners are kept in holding cages when they are awaiting transport or escorts, when

they are waiting to see medical or mental health staff and, for some of them, when they are supposed to be receiving individual counseling (even in cages that sit inside a clinician's office) or participating in "group therapy" sessions (inside cages that are arranged in semi-circles). Some of the cages are small, many are in disrepair (with paint peeling in them), and most of them are dirty. Many of them lack seats, so that prisoners must engage in "group therapy" standing up, or a prisoner who may be in crisis and awaiting transport must manage to remain upright until his escort arrives. In the hallway outside the infirmary at CIM an officer told me that they try to keep the prisoners who are waiting to see a nurse or doctor—and who, therefore, presumably have some sort of medical problem—"in the small cages no more than 4 hours." Inside the infirmary at CIM, a large group of about 10 Sensitive Need Yard prisoners or "SNY" (those who need to be separated from other prisoners because of special vulnerabilities or for other reasons) were [184] sitting and standing together in a much larger cage—but still clearly a cage—waiting to receive medical help.

f. Overcrowded Housing Units

345. As I mentioned earlier, many of the housing units in the prisons I visited almost defied description, and ranged from uncomfortable to uninhabitable. It should be noted that the so-called "bad beds" are pervasive in the CDCR; I myself literally saw many hundreds of them in my tours of just eight prisons. Even the prisoners who are housed in traditional cells have been double bunked in cells designed for one. One CIM prisoner told me that he has to lift his legs up whenever his cellmate uses the toilet in their small cell, because his legs otherwise hang over it. As

inconvenient and uncomfortable as this arrangement is, this prisoner is more fortunate than most because he is in a cell.

346 In discussing the dormitory housing units I saw on these tours, I have often referred to them as "makeshift" dormitories, to underscore the way in which they represent an exigent response to the prison overcrowding crisis. The dormitory housing units I saw were in spaces that were originally intended for other uses—first built as gymnasiums and dayrooms. They are *not* appropriate spaces for housing prisoners and, unlike other forms of dormitory housing in some other prison systems, they were not constructed with this purpose in mind. The converted spaces are highly problematic in a number of ways, including the sheer density of the housing; the impossibility of monitoring prisoner behavior (especially in the larger makeshift gymnasium dorms, but also on the dayroom floors where officer stations and sight lines that were designed for cellblocks are obstructed by the bunks); the inadequacy of the toilet and other hygiene-related facilities, ventilation, and heating and cooling systems (all of which entail converting and supplementing existing infrastructure in ways that cannot possibly meet the extraordinary levels of use to which they are subjected); the lack of sufficient, dedicated recreational and programming space, accommodations for basic prisoner privacy needs, appropriate storage for prisoners' personal possessions, and so on.

347. Despite the impermanent and makeshift "feel" of the units, large numbers of prisoners are spending many months and years housed inside the barely habitable spaces. Not [185] only are many of these makeshift dormitories shocking to see—especially the

huge "triple bunk" dormitories located inside gymnasiums—but such housing units are dangerous and degrading, and they are likely to take an especially severe toll on prisoners who have pre-existing mental health and medical problems.

g. Lockdowns

348. Lockdowns appear to me to be used in California prisons far more than I have seen (or heard of) being used in any other prison system in the country. They are particularly problematic when used on such a frequent or long-term basis. Prisoners in CDCR facilities are being confined to their cells, denied programming and recreational activity, and must eat all of their meals in their cells. Elsewhere in the country lockdowns are used as a last resort by prison systems that cannot control their prisoner populations any other way; in some California prisons (C Facility at SVSP, for example), they have become routine, a way of life. When lockdowns and similar modified programs are overused, as they are in California, in my opinion, they represent another clear indication that the prison system is in crisis. This is true in part because lockdowns usually prove to be highly counter-productive. That is, the increased frustration they generate often increases rather than decreases the very tensions and conflicts they are supposed to help alleviate, and they deepen antagonisms between groups (who blame one another for the especially harsh and deprived conditions under which they are forced to live). In the meantime, prisoners—especially those with pre-existing psychiatric conditions—suffer emotionally and psychologically.

349. In fact, the former CDCR Chief Deputy Secretary of Adult Institutions, Scott Kernan, has attributed the extraordinary number of lockdowns

and "modified programs"—as much as 1,435 days at one prison—directly to overcrowding. Crowded conditions lead to riots, which produce long lockdowns that, in addition to subjecting prisoners to especially harsh conditions of confinement that raise tensions, also:

> . . . deflect prison resources so that while correctional officers now must respond to the increased security concerns and maintain watch over an increasingly dangerous prison population, they are [186] not able to assist [prison officials in] addressing the inmates' mental health concerns by escorting prisoners to appointments and providing access to yard.[389]

350. I could not agree more. Yet I saw little evidence in the prisons I visited that this enlightened perspective had altered CDCR's overall sense of urgency about the magnitude of the overcrowding crisis it faces or decreased the willingness of individual wardens to continue to rely on lockdowns as an ill-advised strategy for managing prisoner conflict.

h. Impact of Overcrowding Effects on Quality of Mental Health Care and Suicide Prevention

351. Because of the subjective nature of the experience of mental illness, it is sometimes difficult to precisely measure whether and how the quality of mental health care in a prison system has improved the overall mental health of prisoner/patients. This is one of the reasons that indirect but objective measures—staffing, program and contact hours, waiting times to receive appropriate levels of care, and so

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[389] Coleman Pls.' Trial Ex. 53 at 2 (Declaration of Scott Kernan).

on—are typically relied on to estimate or monitor progress (or deterioration) in the quality of care provided. One obvious exception to this occurs when the subjective suffering associated with mental illness results in someone taking his or her life. Moreover, because of the extreme and tragic nature of suicide, it is regarded as a basic measure of whether and how well a mental health care delivery system is functioning. That is, whatever else such a system does, it should be reasonably effective at preventing its patients from taking their own lives. And, when it does not, it is possible to analyze the events that led up to the suicide, which may help to account for it having happened, and to learn what could have or should have been done to prevent it.

352. This is the logic by which the Special Master's annual "Report on Suicides" is conducted. The information that it contains is revealing, and identifies some of the ways that the overcrowding-related problems that plague the CDCR continue to severely undermine the quality of mental health care provided. For example, the "Report on Suicides Completed in California Department of Corrections and Rehabilitation in Calendar Year 2005"—the seventh [187] such annual report that has been written—was forwarded by the Coleman Special Master on November 26, 2007.[390] The Special Master calculated the number of suicides in CDCR to be 43, 17 more than in calendar year 2004. Nearly three-quarters (72.1%) had a history of suicidal behavior, fully 86% had a history of past mental health treatment. In addition, about a third (32.6%) were housed in an ASU or SHU, and two-thirds (67.4%) were on the Mental Health Services

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[390] Joint Pls.' Trial Ex. 61 at 1-2.

Delivery System caseload at the time of their death.[391]

353. Indications of "inadequate treatment" (including "canceled appointments not rescheduled, referrals not responded to, past medical records not reviewed, unsupported diagnoses, non-compliance with treatment without reassessment, assignment to inappropriate LOC, failure to provide five-day clinical follow-up, [and] failure to provide immediate CPR") were present in three-quarters (74.4%) of the cases. Based on the longitudinal data provided in the Report, it appears that the most recently calculated suicide rate—for 2005—is higher than any previous year. Between 1998 and 2005, the suicide rate has varied somewhat, from a low of 9.3 per 100,000 in 2000 to a high of 26.2 per 100,000 in 2005.[392]

354. A number of the inadequacies in treatment that the Special Master identified appear to be the direct result of the severe overcrowding-related problems from which the CDCR continues to suffer. Thus, the failure to reschedule appointments, respond to referrals, review medical records, reassess treatment compliance, employ appropriate levels of care, and conduct required five-day clinical follow-ups all represent the kind of poor quality of care that comes about in understaffed, overpopulated prison systems. In addition, the Special Master identified a host of other overcrowding-related problems that were likely to have directly impacted suicide rates. These included: the continuing failure of CDCR clinicians "to utilize information available in unit health records (UHRs) or central files (C-Files) or through [188] custody

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[391] *Id*. at 7-9.

[392] *Id* at 10.

referrals," which would have "alerted mental health staff . . . to inmates' relative potential for suicide;" "[f]ailure to screen inmates in confidential settings" which "limit[ed] adequacy of information that clinicians were able to elicit when completing SRACs [Suicide Risk Assessment Checklist] and intake assessments of inmates on admissions or transfers to (particular) facilities; the "[u]ntimely administration and inadequate completion of SRACs . . ." inadequate staff training "on procedures for the initiation and supervision of Keyhea orders guardianships or conservatorships for inmates in need of such support;" and the failure of "clinicians to monitor suicidal inmates more closely and, where appropriate, aggressively refer decompensating suicidal inmates, especially those at Level III and IV custody levels, to DMH programs" and to provide "appropriate crisis-level care until such transfers to DMH progran can be achieved."[393]

355. Finally, the Special Master identified another overcrowding-related problem that he concluded was directly implicated in a number of suicides in 2005. Specifically:

> The crisis in the availability of MHCBs [Mental Health Crisis Beds], which became evident in early 2005, led to the spreading use of "alternative" and supposedly "temporary" housing in Mental Health Outpatient Housing Units (MHOHUs), Outpatient Housing Units (OHUs), and a variety of other holding cells for suicidal inmates for whom no bed was available in an MHCB unit. Defendants' dependence on these alternative placements emerged as a factor in a

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[393] *Id.* at 11-13.

number of suicides in 2005. In addition, an increasing failure by clinicians to refer inmates who were clearly decompensating and in need of treatment at more intensive LOCs contributed to several successful suicides in 2005.[394]

356. Although the Special Master's Suicide Report was based on data that were collected in 2005, I have reviewed the 2006 suicide report and more recent suicide data which indicate that the overall number of suicides in the CDCR has remained high. Moreover, and perhaps more importantly, many of the very problems to which the Special Master has pointed [189] to in his Report as playing an instrumental role in these suicides in 2005 persist in 2008. In fact, the last one mentioned above—the crisis in available MHCBs—has become increasingly problematic, as I will discuss at greater length near the end of this report. In any event, the Special Master's analysis illustrates a clear nexus between overcrowding-related dysfunction, decreased quality of overall mental health care, and an extreme and tragic set of mental health outcomes.

i. Disproportionate Impact of Overcrowding on Vulnerable Parole Population

357. Because they are among the most vulnerable *Coleman* class members, and are so significantly affected by the State's inability to manage the population, I would like to briefly but separately address the group of mentally ill prisoners who cycle back and forth from CDCR prisons to parole, serving short revocation terms for violations of parole. I am informed that these terms cannot exceed twelve months without a revocation extension, and generally

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[394] *Id.* at 11.

average between three and four months. This means that this group of prisoners generally serves their entire revocation terms in reception centers. Documents drafted by the State that I reviewed estimate that more than 10,000 parolees with mental illness were returned to custody in 2005, and more than 6,000 of them are returned for minor or technical violations related to unmet mental health need.[395] The documents I reviewed also show that at any one time, out of the approximately 500 EOP prisoners backlogged in reception centers, some 200 of them are serving parole revocation terms likely related to their mental illness.[396]

358. Based on interviews I conducted with prisoners who were in precisely this situation at CIM and VSPW, and what I have learned about the parole system more generally in California, I understand that mentally ill parolees often do not receive meaningful mental health treatment when they are on parole. More specifically, these parolees often do not have [190] access to appropriate psychiatric medications, or stop taking them as a result of lack of clinical supervision, and then often decompensate.

359. Frequently as a result of their decompensation, many are returned to prison, often for technical or minor violations. Thus, many of the parole violations that return them to prison are directly related to their unmet mental health needs. When they return to prison, these vulnerable prisoners are then packed into overcrowded reception centers. There they find that their out-of-cell time is severely limited and, even with the beginning of the EOP RC program

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[395] Coleman Pls.' Trial Ex. 51 at Exhibit A and B.

[396] Coleman Pls.' Trial Ex. 52 at Exhibit V.

implementation, they receive little individual or group treatment. One of CDCR's senior clinicians stated in a declaration before the Coleman Court that: "In the overall inmate population, approximately 18% of inmates are in the mental health caseload. In the Reception Center population, an even higher percentage of inmates are in need of immediate mental health services at the time of arrival. Upon entry, inmates with mental health needs are often severely decompensated because they have not had access to mental health care resources, particularly medication management, in the community."[397]

360. Based on my observations and my review of documents provided by Plaintiffs' counsel, I have concluded that mentally ill prisoners in reception centers are generally not receiving adequate mental health treatment. In addition, none of the prisoners I interviewed had received meaningful pre-release planning before they paroled. Especially for this group of vulnerable mentally-ill prisoners, the lack of meaningful pre-release planning virtually guarantees their return to prison. Indeed, it was typical for the prisoners in this population whom I interviewed to have multiple releases and revocations in a single year. Moreover, the time that they actually spent on parole between release and revocation tended to be short, sometimes as brief as one day.

361. In addition to being revoked for violations related to their unmet mental health needs, this group of prisoners also appear to receive extensions of their revocation terms for [191] actions related to their mental illness, adding to the cycle of punishment without treatment for mentally ill prisoners in

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[397] Coleman Pls.' Trial Ex. 53 (McAloon Decl.) at 2:19-23.

this overcrowded system. In these inter-related ways, they are doubly or triply affected by the overcrowding that plagues the CDCR and the adverse conditions and policies it generates.

362. Indeed, these prisoners seem to be lost in a "population shuffle" or cycle of "catch and release" that is tremendously destabilizing and life-altering for them. Each time cycle through this dysfunctional system in this way, the probability is increased that they will become sicker, and that their illness will become harder to stabilize and manage.

j. Perniciousness of Overcrowding Effects

363. Finally, as I have tried to show throughout this report, chronic overcrowding has such pernicious consequences in correctional settings in large part because it can impact so many levels and aspects of the prison environment. The closed nature of a prison environment means that its different parts are unusually interconnected, and problems that remain unsolved in part of the environment have a way of reverberating throughout the institution and even the larger prison system. Thus, even though my discussion of the eight institutions I visited focused on specific aspects of the overcrowding-related crises that each facility faced, I continued to be struck by how deficiencies in one part of the institution impacted the services that could be delivered in another area of the prison. The tours and interviews I conducted and the voluminous documents I reviewed all underscore the degree to which the chronic and severe problem of overcrowding in the CDCR is so widespread and its harmful consequences so interconnected that it does not translate to a piecemeal solution, despite the best efforts of the many individual custody and clinical staff members I

encountered who were laboring mightily to overcome this insurmountable obstacle.

[192] D. The Only Remedy to the Continuing Constitutional Violations That Are Primarily Caused by Overcrowding is to Reduce the Population of the CDCR

[193] * * * There are several reasons why no other solution, including ones proposed by the CDCR itself, are inadequate [sic] to the task of resolving this crisis.

367. The first is the urgency of the problem itself, and the unacceptably time-consuming nature of alternative solutions.[402] The Defendants' own projection for providing adequate mental health care beds is 2013 without including the construction projects outside the responsibility of the Receiver. As I will point out below, even this seems unrealistic, given their inability to address the wide range of glaring inadequacies in this system over the last decade. In this context, however, it is fair to note that mentally ill prisoners in California have been subjected to inadequate or non-existent mental health care since long before the Court's order in *Coleman* and the attempts to remedy these problems began in 1995. It has been more than 10 years since these efforts began, and the CDCR is still not in compliance with constitutional standards. Now, under the best case scenario—one that does not necessarily have any better chance of succeeding than prior, similar projections—the class of mentally ill prisoners is being asked to wait many more years before the system can deliver the care to which they are constitutionally entitled. Institutional change in

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[402] Coleman Plaintiffs' Trial Ex. 12.

response to problems this [194] massive and endemic cannot occur on such an incremental basis. In my opinion, this is not only an unreasonable response but also a dangerous one.

368. The second reason that any remedy short of a prisoner release order is unlikely to succeed pertains to the track record and capacity of the CDCR to solve this problem through its preferred methods and in its preferred manner. The severe and chronic overcrowding that plagues the California prison system is so profound and systemic that it appears to have overwhelmed CDCR officials in charge of all administrative functions, undermining their ability to plan, initiate, and implement overcrowding-related program initiatives. The CDCR and its institutions are so beset by the magnitude and multiplicity of the overcrowding-related challenges and crises that they confront on a daily basis that all they appear to be able to do is manage the prisoner population and respond to emergencies. Constitutional and professional standards and goals have fallen by the wayside, and so too has the capacity to anticipate the next round of overcrowding-related set of problems and plan to address it, let alone to effectively resolve the panoply of pre-existing overcrowding-related issues with which the Department is struggling.

369. On October 29, 2007, for example, CDCR officials filed their final plan to address the serious shortfall of small management yards ("SMYs") that are necessary for defendants to be able to provide even the basic minimum of 10 hours a week of yard time for prisoners housed in administrative segregation units.[403] The plan was in response to a *Coleman*

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[403] *Coleman* Pls.' Trial Ex. 39.

Court order to implement various measures, including the construction of these yards, in an effort to reduce the high rate of suicides in CDCR's administrative segregation units.[404] The Court ordered that CDCR construct all of the necessary yards no later than the end of fiscal year 08/09.[405] However, CDCR's plan lists a series of reasons and excuses why they cannot [195] comply with the Court order and, thus, will not be able to provide prisoners in administrative segregation with even 10 hours a week of yard for several years.[406] In response to the Court's order to also maximize the existing SMYs while the shortfall is addressed, CDCR's plan stated that: "[t]he institutions do not currently have sufficient escort and security staff to expand the Administrative Segregation Unit Yard Program beyond the hours currently offered."[407]

370. Moreover, I have reviewed documents indicating that, on the very day that the defendants filed their plan, they also submitted a request to the Legislature to reduce the scope of their small management yard (SMY) project to construct 80 (SMYs) for prisoners housed in administrative segregation units at Mule Creek, Solano State Prison,

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[404] *Coleman* Pls.' Trial Ex. 45.

[405] *Id.*

[406] *Coleman* Pls. Trial Ex. 39 at 3 (Defendants' Plan states that they cannot comply with the Court Order to complete construction of all 476 SMYs by June 30, 2009, for the following reasons that include: the absence of any viable mechanism for funding the project in the current budget year, the existence of various statutory code sections that will delay the funding, bidding and approval of plans, and long procurement periods for obtaining the necessary materials ranging from 23 weeks for fabricated enclosures to 33 weeks for steel toilets and locks).

[407] *Coleman* Pls. Trial Ex. 39 at 3.

Wasco State Prison and RJ Donovan. The request informed the Legislature that the change in scope would postpone the construction of 20 SMYs at Solano State Prison and revert $395,000 dollars to the budget.[408] This kind of delay—here for construction of 20 small management yards—when the CDCR has been ordered to build a total of 1,162 additional such yards does not bode well for its ability to comply with the *Coleman* court's order to complete the construction by the end of Fiscal Year 2008/2009."[409]

371. Finally, the CDCR's proposed solution of incrementally increasing the system's capacity by adding new facilities and additional staff, and doing very little else, not only is expected to take far more time than this urgent problem permits, with much uncertainty surrounding the CDCR's capacity to deliver on even its own distant projections, but the very [196] nature of approach is inadequately conceived. As jail and prison construction began in earnest in the late 1980s and early 1990s, most scholars understood that correctional systems could not build their way out of the overcrowding problems they faced. For example, as two well-known experts noted, "projections show that such construction will not alleviate crowding if past trends in incarcerative policies and crime rates continue."[410] They were right.

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[408] *Coleman* Pls. Trial Ex. 107.

[409] *Coleman* Docket 2644 at ¶ 2 (Order re Small Management Yards).

[410] H. Pontell & W. Welsh, Incarceration as a Deviant Form of Social Control: Jail Overcrowding in California, 40 *Crime & Delinquency* 18-36 (1994), at 19. Further, as they also noted: "There also is a long time lag between current problems and the potential opening of new facilities. There is also no guarantee, nor any body of systematic scientific evidence, that shows that

372. Indeed, if the last two decades of experience in California have proven anything, it is that the overcrowding crisis cannot be remedied through prison construction programs. The *Plata* Receiver is correct when he argues that: "[D]espite spending billions of dollars on construction, the level of overcrowding in California's prison system has not decreased; despite waves of prison expansion overcrowding has now reached crisis levels . . . By 2007, 19 institutions were at or above 200 percent of [capacity]. To summarize, despite massive waves of construction, prison overcrowding has grown worse in California."[411]

373. Perhaps even more pointedly, there is evidence that the *worsening* prison overcrowding crisis has had a *corresponding* effect on the quality of mental health care afforded *Coleman* class members. In his May 31, 2007 Report to the Court, the Coleman Special Master concluded that "nearly 12 years after the determination that mental health service in CDCR were egregiously unconstitutional, hundreds certainly, possibly thousands, of CDCR inmates/patients, all members of the Coleman class certified in the early 1990s, are still looking for beds at the level of treatment their mental health requires."[412] More than a year [197] later, that still appears to be the case. In fact, the situation appears to be worsening, not improving, in a number of respects.

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when such new facilities are opened they will solve the overcrowding problem" (at 32).

[411] Joint Pls.' Trial Ex. 26 at 9.

[412] Joint Pls.' Trial Ex. 35, at 9.

IV. CONTINUING CONSTITUTIONAL VIOLATIONS THAT ARE PRIMARILY CAUSED BY OVERCROWDING SHOULD BE REMEDIED BY OVERALL POPULATION REDUCTIONS TO BETWEEN 100-145% OF CDCR'S DESIGN CAPACITY

379. Because CDCR is an enormous and enormously complex system, there is no simple formulaic method for determining the precise reductions in the size of its prisoner population that will eliminate the continuing constitutional violations that are primarily caused by overcrowding. Instead, I believe that a range of reasonable goals can be established, ones [201] based on the most intelligent and informed estimates, reliable data, and appropriate, meaningful parameters. These goals can and should be adjusted as the nature and magnitude of the constitutional violations are continually monitored and assessed.

380. As a starting point for establishing the range of reasonable goals, let me begin with what was once understood to be collective correctional wisdom (rather than an expedient approach to a largely politics-driven problem). As I mentioned earlier in this report, until the massive overcrowding crises that befell correctional systems in the United States beginning in the mid-1970s, most correctional scholars, experts, and administrators viewed prisons as dangerously overcrowded when they began to approximate 100% of their design capacity. The wisdom in this view was based on several commonsense assumptions. The first was that prisons were virtually always designed sparsely, from very basic and minimalist perspectives and premises, so that a prison that was reaching 100% of its capacity really was pushing against the limits of the number of prisoners that it could safely

and humanely hold. In a related way, prison design traditionally maximized housing capacities and minimized space allocated to programming needs, opportunities, and demands. Thus, when a prison began to operate at near its rated capacity, there was typically little or no space available to pursue all but the most basic programming options. A prison administration that wanted to preserve at least some of its programming possibilities knew that those options would be all but foreclosed as its institutions neared 100% of capacity. In addition, correctional administrators, especially, knew that they were likely to face a number of unexpected contingencies and challenges, and that they would need at least some flexibility—to move or separate prisoners in response to conflict or confrontation, to accommodate to the special needs of a changing inmate population, or to address any one of a number of other unforeseeable but inevitable demands—that had not been factored into an original design capacity.

381. Aside from the way that the overcrowding crises of the last several decades has forced administrators to accept the unthinkable, nothing has changed to undermine that earlier view—namely, that a prison that is approximating 100% of its design capacity is beginning to place its staff and inmates at risk. With this in mind, I see no reason why a proposed range of [202] goal-based remedies for what are significant and chronic constitutional violations should not at least begin with what once was regarded as the outer limit of acceptability, albeit, in this instance, as a concession to exactly how dire a situation has been allowed to come about, set as its most ambitious goal.

382. How then to set the *maximum* allowable population? Fortunately, there is an existing estimate that has been proffered by informed analysts that I believe provides a useful (albeit very conservative) outer limit. The Corrections Independent Review Panel that was appointed by Governor Schwarzenegger undertook an analysis of the various ways that an acceptable CDCR "capacity" could and should be defined and established. Entirely consistent with the observations that I have made throughout this report, the panel concluded in 2004 that the overall population of male prisons in the state "exceeds a safe maximum, and individual housing units in some prisons are so severely over-crowded as to be at a crisis stage."[417] As part of its work, the panel convened a group of experienced wardens to determine what they termed the "Maximum Operable Capacity" (MOC) of the prisons system—the percent of design capacity at which a "prison can be operated both safely and can provide programming for every inmate, consistent with the inmate's ability."[418] The "programming" that was contemplated in calculating the MOC included educational, vocational, substance abuse, and other rehabilitation programming. It explicitly did not take into account the kind of programming that would be required to provide constitutionally adequate mental health and medical treatment.[419] Nonetheless, the Panel concluded that the statewide MOC for male prisons was 145% of design capacity.[420]

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[417] Joint Pls' Trial Ex. 4 at 124.

[418] *Id.* at 161.

[419] *Coleman* Pls'. Trial Ex. 108 at 113,1. 15-17.

[420] Joint Pls' Trial Ex. 4 at 124. Design capacity was determined to be 76,879 inmates at that time. *Id.* On January 25,

[203] 383. The Corrections Independent Review Panel's estimate assumed several other things. Thus, the use of all "bad beds" would have to be ended, so that adequate program space would be available. Of course, it also assumed that, in addition to available space, there would be "staff with requisite experience" provided to manage effective programming.[421] Indeed, the Panel noted that the CDCR estimates of appropriate staffing "packages" that were operative at that time needed to be updated "to reflect position reductions, redirections, accommodations for 'overcrowding,' court decisions and other mandates that have affected staffing allocations."[422] Moreover, as I noted above, the Panel's estimate of an MOC did *not* specifically contemplate, take into account, or attempt to calculate the *additional* space and staffing levels that would be required to provide constitutionally adequate mental health and medical care.

384. In fact, of course, there is every reason to believe that the necessary space and staffing levels needed to provide constitutionally adequate mental and medical are truly substantial. That is certainly my own judgment; it is the very clear conclusion reached on the basis of the observations and analysis I have detailed in much of this report. It also reflects the judgment of numerous other independent experts who have evaluated, analyzed, and monitored the CDCR.[423] In fact, although I have not attempted to

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2007, the Little Hoover Commission issued a report updating the design capacity to 83,219. Joint Plts. Trial Ex. 3 at 19.

[421] Joint Pls' Trial Ex. 4 at 161.

[422] *Id.* at 126-27.

[423] Those numerous experts include, as I noted earlier, in addition to the Corrections Independent Review Panel, members of the Little Hoover Commission and the CDCR Expert Panel.

provide a quantitative estimate of the extent of the shortcomings—in space and personnel—that plagues the CDCR in this regard, the *Coleman* Special Master has done so. Specifically, he reported to the Court on May 31, 2007 that: "Given the inadequacies of programming space, program beds and mental health staffing, it is clear that a significant portion of the MHSDS caseload is not receiving the necessary mental health services . . . defendants cannot meet at least a substantial portion, amounting in [204] some loose amalgam to about 33 percent, of acknowledged mental health needs with current staffing resources. Insufficient intensive mental health treatment beds and a chronic lack of programming space for mental health treatment contribute further to defendants' inability to meet required mental health services."[424] This quantitative estimate of the current shortfall brought about by inadequacies in space, beds, and housing—fully a third of mental health needs unmet—suggests that the magnitude of the incremental needs ignored in the Panel's estimate of maximum operable capacity is substantial.

385. When these crucial mental health and medical treatment needs are taken into account—as they must be in any calculation aimed at addressing the primary cause of these continuing constitutional violations—then the appropriate percentage for maximum operable capacity would certainly be lower than the Panel's and wardens' estimate of 145%. Thus, in this important sense, a limit of 145% of design capacity can only be regarded as a very conservative estimate of the MOC, and seems an appropriate figure to establish as the *outer* limit or *maximum* capacity in a

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[424] Joint Pls' Trial Ex. 35 at 12-14.

range that is intended to eliminate the constitutional violations that are at issue here.

386. There is another reason to regard the Independent Review Panel's estimate of a viable MOC as a very conservative outside limit. Specifically, it is based on the judgments of a group of experienced California wardens, many of whose own perspectives on "Maximum Operable Capacity" were likely forged in a system in which a certain amount of institutionalized acceptance of overcrowding has occurred. I note, for example, that the Plata Receiver described what he called "CDCR's institutionalized acceptance of overcrowding and the lowering of correctional standards to accommodate overcrowding."[425] In fact, the Receiver documented not only the decades of prison overcrowding in California but also the parallel [205] evolution of "a correctional mindset that allows *overcrowding* rather than *sound correctional management* to drive crucial construction and prisoner management policy."[426]

387. Moreover, the Receiver identified the same failure to take medical, mental health, and dental care programming needs into account in the CDCR's Facility Master Plans (spanning 1993-2003) as was reflected in the Corrections Independent Review Panel's report. As he put it: "All the plans focus on corrections, as if medical, mental health, and dental care have no place in prison design, prison construction, or prison management."[427] In fact, the Receiver found that the acceptance of overcrowding was institutionalized to such a degree in CDCR management

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[425] Joint Pls' Trial Ex. 26 at 10.

[426] *Id.* at 10 (emphasis in original).

[427] *Id.* at 11. (emphasis in original).

that it knowingly planned construction of even its newest prisons to provide at most fifty percent of all health care related space needs, "ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity."[428] These facts suggest that the Maximum Operable Capacity would actually have been quite a bit lower than 145% if the Corrections Independent Review Panel had taken these critically important needs into account.

388. At a minimum, then, using the Panel's estimate of 145% as a very conservative outside limit, remedial steps should be taken to reduce CDCR's prison population to its viable, defensible maximum operable capacity. This would mean that all bad beds must be eliminated,[429] sufficient program space must be identified and made available, and the number of inmates not to exceed appropriate numbers of available, qualified staff to provide necessary programming. Necessary staffing must be calculated in such a way as to provide programming opportunities and sufficient custody/escort staff to enable that programming to occur. Indeed, it is not clear that, given the "serious staffing shortfalls" that continue to plague CDCR, its [206] prisons can possibly safely and humanely accommodate even 145% of capacity (much less the near-double capacity they now face).[430]

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[428] *Id.* at 20. Even the personnel, accounting, inmate records, procurement, receiving and release, and family visiting areas were built to accommodate only 130 percent overcrowding.

[429] This task, alone, will be difficult to accomplish. According to recent data, there are 13,791 "non-traditional" beds throughout the prison system. Joint Pls.' Trial Ex. 68.

[430] "[O]vercrowding is accompanied by serious staffing shortfalls for both clinical providers and correctional officers." Joint Pls' Trial Ex. 26 at 11.

389. Moreover, as I have suggested, a "maximum operable capacity" that provides for the constitutional delivery of mental health care must incorporate and take centrally into account the mental health treatment standards established by the *Coleman* Court. To parallel the Corrections Independent Review Panel's assumptions in this context, then, all "bad" *mental health* beds must be eliminated. For example, this includes reducing the population to eliminate the use of alternative crisis beds, EOP "overflow" housing that does not have appropriate space for individual or group mental health contacts, RC EOP housing for EOP stays greater than 60 days, and DMH units such as those currently run in SVSP D-5 and D-6 and CMF P-2 and P-3, which are not set up to provide care consistent with inpatient standards.

390. Furthermore, the programming considerations of the Independent Review Panel must be expanded to reflect the requisite mental health "program" that is set forth in the *Coleman* remedy. Thus, adequate mental health programming space must be afforded under any defensible definition of the MOC. Moreover, whatever operable capacity is finally implemented must also be related to the number of mental health and custody staff in the prison system who are tasked with providing mental health care. For example, as I noted above, the Special Master found that current staffing cannot provide for roughly one-third of the prisoners with identified mental illness. Finally, the maximum operable capacity must also account for the intersection of space availability and staffing levels. This means, as the Receiver noted, California's long-standing policy of building "only to base staffing levels"—a policy that "has left the CDCR in crisis regarding the clinical space

needed to provide constitutional levels of access to health care"—must be correspondingly changed.[431]

[207] V. CONCLUSION

391. Numerous previous court orders—most of which were issued a considerable period of time ago—and virtually every other approach to judicially-mandated institutional change of which I am aware have been tried and failed to solve this chronic (and in many ways, worsening) problem. In my opinion, a carefully crafted prisoner release order is the only remedy that is capable of addressing this severe overcrowding crisis and beginning the process of finally solving the wide range of dangerous and debilitating problems it has brought about.

Dated: August 15, 2008

/s/ CRAIG HANEY
CRAIG HANEY

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[431] *Id.* at 22.

IN THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT
OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

EXPERT REPORT OF PABLO STEWART, M.D.

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[1] EXPERT REPORT OF PABLO STEWART, M.D.

I. INTRODUCTION

1. I am a physician licensed to practice in California, with a specialty in clinical and forensic psychiatry. A true and correct copy of my current curriculum vitae is attached hereto as *Exhibit A*.

2. In 1973, I earned a Bachelor of Science Degree at the United States Naval Academy in Annapolis, Maryland, with a major in chemistry. In 1982, I received my Doctor of Medicine from the University of California, San Francisco, School of Medicine. In 1985, I received the Mead-Johnson American Psychiatric Association Fellowship for demonstrated commitment to public sector psychiatry and was selected as the Outstanding Psychiatric Resident by the graduating class of the University of California, San Francisco, School of Medicine. In 1985-1986, I served as the Chief Resident of the U.C. San Francisco Department of Psychiatry at San Francisco General Hospital and was responsible for direct clinical supervision of seven psychiatric residents and three to six medical students.

3. Throughout my professional career, I have had extensive clinical, research, and academic experience in the diagnosis, treatment, and prevention of mental illnesses in correctional and other institutional contexts. In my work, I have specialized in community and correctional treatment programs for individuals with chronic and severe mental illnesses, as well as substance abuse and related disorders. I have also specialized in diagnosis, treatment, and care programs for persons with Major Depressive Disorder and Post Traumatic Stress Disorder (PTSD), in the

management of patients with dual diagnoses and the application of psychotropic medication to such individuals, and in the history and use of psychotropic medications in institutionalized populations. I have designed and taught courses in correctional psychiatry at the University of California, San Francisco. I have also designed and taught courses on the protocols for identifying [2] and treating psychiatric patients with various disorders and have supervised psychiatric residents in teaching hospitals. I have worked closely with local, state and federal governmental bodies to design and present educational programs about psychiatry, substance abuse, and preventative medicine.

4. I also have extensive experience managing, monitoring, and reforming correctional mental health systems. Between 1986 and 1990, I was the Senior Attending Psychiatrist for the Forensic Unit of the University of California, San Francisco, which was located at San Francisco General Hospital. In that capacity, I had administative and clinical responsibility for a 12-bed maximum security psychiatric ward and worked as the liason with the Jail Psychiatric Services of the City and County of San Francisco. My duties in that position included advising the San Francisco City Attorney on issues pertaining to forensic psychiatry.

5. Between August 1988 and December 1989, I served as the Director of Forensic Psychiatric Services for the City and County of San Francisco. In that capacity, I had administrative and clinical oversight responsibility for the psychiatric care provided to the inmate population in San Francisco at both the county jails and in the 12-bed locked inpatient treatment unit at the San Francisco General Hospital. At

the time, mental health care in the San Francisco's jails was subject to a consent decree in the case *Stone v. City and County of San Francisco,* 968 F.2d 850 (9th Cir. 1992). In the 1980s, San Francisco's jails were overcrowded, and the *Stone* consent decree included remedies designed to limit overcrowding. While I was working as the Director of Forensic Services in San Francisco, the plaintiffs in the *Stone* case brought contempt proceedings against the City because of ongoing overcrowding that they asserted violated the consent decree.

6. I have also served as a psychiatric expert or consultant to various federal courts or other organizations implementing remedial decrees covering the provision of mental health care in correctional institutions. For ten years, between April 1990 and [3] February of 2000, I served as both a medical and a psychiatric expert for the United States District Court for the Eastern District of California in the consent decree case *Gates v. Deukmejian,* ED. Cal. Case No. CIV S-87-1636. Among other things, that case involved the provision of adequate psychiatric care to mentally ill inmates at the California Medical Facility (CMF) in Vacaville, California. The *Gates* Consent Decree included various restrictions on overcrowding, and at times the parties in the case agreed to limitations on the size of the population of mentally ill inmates at CMF in order to prevent the mental health programs there from being overwhelmed and undermined by excessive transfers of mentally ill prisoners from other prisons. During my time monitoring CMF, California introduced its new state-wide Mental Health Services Delivery System (MHSDS) as part of the implementation of the remedy in the *Coleman* case. Given the requirements of the new MHSDS being implemented at CMF, the

California Department of Corrections and Rehabilitation (CDCR) limited the number of inmates allowed to transfer to CMF in order to give the new MHSDS programs the ability to provide adequate psychiatric care.

7. My experiences working on the *Gates* case also informed me about the difficulty of providing mental health services in locked, high security units. As part of the *Gates* case, CMF was forbidden from housing mentally ill inmates in its Willis Unit, a three-tier administrative segregation unit, because of the severity of conditions and the acknowledged difficulty of providng adequate mental health services in this type of setting.

8. Between October 1996 and July 1997, I served as a psychiatric expert for the United States District Court for the Northern District of California in the case of *Madrid v. Gomez,* 889 F. Supp. 1146 (N.D. Ca. 1995), an omnibus case involving psychiatric care and other issues at Pelican Bay State Prison in Cresent City, California. In my work on that case, I gained first-hand knowledge concerning the severe impact of prolonged isolation in segregation units on mentally ill inmates, as well as a concrete [4] understanding of the need for constant monitoring of both non-mentally ill and mentally ill inmates in lock up units in order to prevent any further decompensation, since housing in these units by itself contributes to psychiatric instability.

9. Between July of 1998 and February of 2004, I served as a psychiatric consultant to the National Council on Crime and Delinquency (NCCD) and subsequently for the Institute on Crime, Justice and Corrections at Washington University (when it took over monitoring responsibilities from NCCD) in their

efforts to monitor juvenile detention and treatment facilities operated by the State of Georgia. In that case, I monitored an Agreement between the United States Department of Justice and the State of Georgia designed to improve the quality of care in its juvenile detention facilities. The Agreement encompassed mental health care, medical care, educational services, and treatment programs. Overcrowding was a major issue in the Georgia case. It was clear from the outset of the monitoring that overcrowding severely limited the ability of staff in the Georgia youth facilities to meet the medical and mental health needs of the youths in their charge. As part of the Agreement to address overcrowding, Georgia was required to limit the intake of youths from the counties into their state juvenile system in order to prevent the fragile mental health system from being overwhelmed. Also as part of the monitoring in that case, Georgia created significant new mental health treatment programs with dedicated staffing and capacity limitations, including most significantly a new inpatient treatment facility for boys and a second new inpatient treatment facility for girls. The Agreement also included a provision forbidding the prior practice of housing suicidal youths in administrative segregation units, and required "mainstream" housing and suicide watch monitoring of such youths. The youths would go to school and work during the day, and would continue their suicide watch in their housing units overnight. This provision was introduced because it had become clear under the prior practices that suicidal youths frequently would not come forward with their suicidal feelings because they did not want to be locked down in administrative segregation for suicide watch. [5] This demonstrated to me the dangerous and damaging nature of isolation in locked units for suicidal individuals. It also demonstrated to me the dangerous nature of punitive suicide watch conditions when they discourage suicidal individuals from coming forward and seeking treatment.

10. Between June of 2003 and December of 2004, I was hired by the State of New Mexico as a defense expert for the implementation phase of the psychiatric sections of the "Ayer's Agreement" covering the New Mexico Corrections Department (NMCD). The Agreement was a settlement between attorneys representing New Mexico prisoners and the NMCD concerning the provision of adequate psychiatric care for inmates in New Mexico's highest security facility. The Ayers Agreement concerned a mental health treatment program in a disciplinary detention unit similar to the Security Housing Unit (SHU) at Pelican Bay State Prison. The treatment program implemented in the unit was based in part on the treatment standards for the Psychiatric Security Unit (PSU) mental health care programs in California. New Mexico implemented the new treatment program with an acknowledgement that they needed to maintain minimum clinical staff-to-inmate ratios given the severe nature of the housing conditions in the locked-down unit, and the potential for mental decompensation.

11. I have also worked as an expert consultant for the United States Department of Justice (USDOJ) on inspections and remedial work in connection with youth facilities in California and Michigan. In August and September of 2003, I was retained as a medical and psychiatric expert for the USDOJ in connection with an inspection of the N.A. Chaderjian Youth Correction Facility in Stockton, California. In that

inspection, we looked at overcrowding and whether the level of psychiatric care being provided met constitutional minimums, based on the number of wards and the limited number of staff. We concluded that the facility was badly overcrowded and understaffed. At the time, the facility consisted entirely of locked units, and the inspection found that the staff failed to provide minimally adequate medical and mental [6] health services, that the facility locked down its wards excessively, that medication delivery was faulty, that the level of ward access to yard and recreation was insufficient, and that the institution's suicide prevention efforts were underdeveloped, overwhelmed, and ineffective. All of these problems were, in my opinion, closely correlated with the extensive overcrowding that existed at that time at that institution. Moreover, these types of problems are typical in the overcrowded systems with which I have been involved in one capacity or another.

12. Between March of 2003 and the summer of 2006, I worked as an expert for the USDOJ in connection with inspections to identify and remedy various problems at the Maxey Training School, a youth facility with large medical and mental health treatment programs in Whitmore Lake, Michigan. The case involved the adequacy of medical and mental health care provided at the facility. It did *not* involve overcrowding. The case did involve issues around excessive lock-downs of suicidal youths. One of the remedies implemented as a result of the proceedings was a requirement that the institution handle all cases of suicidal wards on an "outpatient basis" in the regular housing units, and that any suicidal behavior that could not be handled in this manner would result in a transfer to an outside

psychiatric hospital. The case also involved general medical and psychiatric conditions.

13. I have presented numerous papers before mental health professionals, prosecuting and defense attorneys, probation officers, and judges, and have published in professional and peer-reviewed journals on topics including prison mental health services, dual diagnosis, mental illness, alcohol and drug abuse, and the treatment of substance abuse. These presentations and publications include: "Classification of High Risk and Special Management Prisoners, A National Assessment of Current Practices" (2004); "Cultural Considerations in Working with the Latino Patient" (2002); "Psychiatric Complications of the Methamphetamine Abuser" (2001); "The Assessment, Diagnosis, and Treatment of the Patient with Multiple Disorders" (2001); "Managing [7] People of Different Pathologies in Mental Health Courts" (2000); "Model for Health Appraisal for Minors Entering Detention" (2000); "Co-Occurring Disorders: Substance Abuse and Mental Health" (2000); "The Dual-Diagnosed Client" (2000); "Psychiatric Assessment in the Criminal Justice Setting, Learning to Detect Malingering" (1999); "Working With the Substance Abuser in the Criminal Justice System" (1999); "Mental Illness and Drug Abuse" (1999); "Alcoholism: Practical Approaches to Diagnosis and Treatment" (1999); "Criminal Justice and Substance Abuse" (1999); "Impulse Control Disorders" (1999); "Major Depressive Disorder" (1999); "Substance Abuse and Major Depressive Disorder" (1999); "Mental Illness and Substance Abuse Assessment: Diagnosis and Treatment Planning for the Dually Diagnosed" (1998); "Assessment and Treatment of the High Risk Offender" (1999); "Assessment of Substance Abuse" (1995); "Attention Deficit Disorder,

Substance Abuse, Psychiatric Disorders and Related Issues" (1994); and "Psychiatry, Homelessness, and Serious Mental Illness" (1994).

14. I am currently a Diplomate of, and have served as an Examiner for, the American Board of Psychiatry and Neurology.

15. Since 1986, I have held academic appointments as Clinical Instructor, Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor in the Department of Psychiatry, University of California, San Francisco, School of Medicine. I received the Henry J. Kaiser Award for Excellence in Teaching in 1987 and was selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic years 1988, 1989, 1990-1991, and 1994-1995. I designed, planned, and taught "Drug and Alcohol Abuse" and "Alcoholism," one-unit courses covering major aspects of drug and alcohol abuse; supervised fourth year medical students in the care of dually diagnosed patients at the Psychiatric Continuity Clinic, Haight Ashbury Free Clinic; facilitated a weekly psychiatric intern seminar on "Psychiatric Aspects of Medicine," and lectured on addictionology and substance abuse to the School of Pharmacy, University of California, [8] San Francisco. I also coordinated a course on Prisoner Health at UC San Francisco School of Medicine between January 2002 and January 2004.

16. I have held numerous positions with responsibility for ensuring the quality of clinical services provided by inpatient and community-based programs. From 1997 to 1998, I was Director of Clinical Services for San Francisco Target Cities Project. I also served as (1) Medical Director of the Compre-

hensive Homeless Center, Department of Veterans Affairs Medical Center in San Francisco, where I had overall responsibility for the medical and psychiatric services at the Homeless Center; (2) Chief of the Intensive Psychiatric Community Care Program, Department of Veterans Affairs Medical Center in San Francisco, a community-based case management program; (3) Chief of the Substance Abuse Inpatient Unit, Department of Veterans Affairs Medical Center in San Francisco, where I had overall clinical and administrative responsibilities for the unit; and (4) Psychiatrist, Substance Abuse Inpatient Unit, where I provided consultation to the Medical/Surgical Units regarding patients with substance abuse problems.

17. I also served as a Physician Specialist to the Westside Crisis Center, San Francisco, from 1984 to 1987, and to the Mission Mental Health Crisis Center from 1983 to 1984. I was the Chief of Psychiatric Services at the Haight Ashbury Free Clinic from 1991 until February 2006. I also worked as a Technical Assistance Consultant to the Center for Substance Abuse Treatment, which is part of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services.

18. I have also been employed as Psychiatric Consultant to the San Francisco Drug Court and to the Hawaii Drug Court.

19. I currently work as a private psychiatric consultant and as a Clinical Professor in the Department of Psychiatry at the University of California, San Francisco, School of Medicine.

[9] 20. I have been retained by plaintiffs' attorneys in the *Coleman* and *Plata* cases as an expert on prison medical care and prison psychiatry and the

impact of overcrowding on prisoners' medical and mental health, including how prison overcrowding detrimentally affects prisoners' mental health and interferes with the ability of prison officials to meet the existing and increased medical and mental health needs of the prisoners in an overcrowded system. I have also been asked to render my opinion with respect to whether overcrowding within the California Department of Corrections and Rehabilitation (CDCR) is the primary cause of the current unconstitutional conditions experienced by members of the *Coleman* and *Plata* class. Finally, I have been asked to address whether other relief — that does not address overcrowding — will remedy the ongoing constitutional violations in a timely and effective manner. My opinions, based upon the evidence that I have reviewed to date documenting current conditions within the CDCR, on my tours of Deuel Vocational Institute (DVI), California State Prison/Solano (Solano), and Salinas Valley State Prison (SVSP), and on my professional knowledge and my experiences working in similarly overcrowded correctional settings, are set forth below.

21. Prior to rendering any opinions, I reviewed a variety of reports, documents and other materials relevant to the current condition of the CDCR. A complete list of the materials I have reviewed is attached hereto as *Appendix B*.

II. OPINIONS

22. My opinions and bases for them are as follows.

A. *Opinion 1*: Overcrowding Within The CDCR Is The Primary Cause Of The Constitutional Violations Currently Experienced By *Coleman* And *Plata* Class Members.

1. *My Knowledge and Experience With Overcrowded Systems*

23. My opinion that overcrowding within the CDCR is the primary cause of the ongoing constitutional violations is based on my experience with other overcrowded [10] correctional systems and mental health programs, on my knowledge of the psychiatric and social science literature regarding the effects of overcrowded jail and prison conditions on the mental health of inmates, on the documents I have reviewed as part of my preparation of my opinion in this case, on the prison tours conducted in this case, and on my personal experiences assessing and treating individual inmates within the context of overcrowded correctional systems. In particular, my opinion is based on my experiences managing psychiatric care in the San Francisco County jail system in the 1980s, when it was overcrowded. It is also based on my experiences with the overcrowded youth corrections system in Georgia. Overcrowding was also an important factor in the failure of the California Youth Authority to provide adequate medical and mental health care to its wards that was revealed in my inspection of the N.A. Chaderjian Youth Corrections Facility in 2003 for the USDOJ. In addition, while the psychiatric programs at the California Medical Facility were not typically overcrowded during the time that I served as an expert on the *Gates v. Deukmejian* case, there were times when the quality of care in the Outpatient Psychiatric Program (which became the Enhanced Outpatient Program (EOP) when the institution transitioned to *Coleman* programs) was undermined by a combination of insufficient staffing to meet the severity of the mental health problems presented in the EOP setting, along with insufficient treatment space, insufficient custodial staff, and a lack of back-

up coverage when clinicians were out sick or on vacation. As discussed below, I encountered similar conditions on my recent prison tours of Deuel Vocational Institute, California State Prison Solano, and Salinas Valley State Prison.

24. In addition, I am familiar with the manner in which housing conditions that tend to worsen mental illness among chronic mentally ill patients become more common in an overcrowded system. For example, it is well established that prolonged isolation and lack of stimulus of the sort that is commonly experienced when inmates are housed in administrative segregation and other high security housing units for long [11] periods of time tend to exacerbate both the symptoms of mental illness and the underlying pathologies themselves. Indeed, these conditions are known to even cause symptoms of mental illness in individuals with no psychiatric history prior to being confined in this manner for long periods of time. Similarly, it is well established among psychiatrists that environmental and social stress of the type experienced in crowded dormitories tends to aggravate mental illness. In addition to finding these conditions at CDCR prisons with full mental health treatment programs, they are also common in reception centers that screen, assess, and process inmates when they first enter a prison system. Reception centers typically confine inmates to their cells for much of the day either for security reasons or because they do not have much out-of-cell programming available. In overcrowded systems such as the CDCR today, inmates tend to spend significantly longer periods of time in reception centers.

2. *The Characteristics Typically Seen in Overcrowded Systems*

25. In my professional opinion, overcrowded prison systems are characterized by several types of endemic correctional and care delivery problems which tend to reinforce and exacerbate each other. Two closely intertwined problems endemic to overcrowded systems are the shortages of staff and treatment space. In addition to the fact that there are simply more inmates for correctional officers to monitor, for mental health workers to treat, and for medical staff to treat, there is also frequently less treatment space in which to provide services to these inmates, and fewer correctional officers to provide escorts to medical and psychiatric appointments.

26. A third endemic problem in overcrowded systems is that there are increased population pressures on administrative segregation and other locked units, and inmates tend to stay in these units for longer periods of time. In crowded systems, there are pressures to double-cell psychiatrically-impaired inmates in administrative segregation. In addition, overflow administrative segregation units are often created in [12] overcrowded systems, which stretches limited staffing resources and yard space and results in the institution being less able to provide inmates with access to basic privileges like yard, and showers. Because of this, the inmates in these units spend more and more time locked in their cells, and have fewer interactions with other individuals.

27. A fourth endemic problem is that the number of inmates experiencing psychiatric crisis, medical problems, and/or psychiatric decompensation tends to

soar,[1] causing overcrowding in mental health care units responsible for providing suicide watch and other forms of crisis psychiatric care. This often results in the creation of "overflow" crisis units, which are ill equipped to provide the level of psychiatric care required by this population.

28. A fifth common problem is that access to inmate work, exercise, vocations, counseling, and education programs tends to be reduced and/or in many cases eliminated, leading to greater idleness on the part of inmates.

29. A sixth endemic problem is the overcrowded, dangerous, and chaotic housing environments themselves. Given the shortage of space to house inmates, more vulnerable mentally ill inmates are housed in crowded gyms, dayrooms, and other makeshift environments where the stress of living in close quarters and the threat of violence exacerbate their mental illness. Due to their overwhelmingly overcrowded nature, these make-shift housing units threaten both

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[1] *See* P. Paulus, G. McCain, V. Cox, "The Relationship Between Illness Complaints and Degree of Crowding in a Prison Environment," *Environment and Behavior* 8 (1976) at 283, 288; P. Paulus, G. McCain, V. Cox, "Death Rates, Psychiatric Commitments, Blood Pressure, and Perceived Crowding as a Function of Institutional Crowding," *Environmental Psychology and Nonverbal Behavior* 3 (1978) at 107, 115; V. Cox, P. Paulus, G. McCain, "Prison Crowding Research," *American Psychologist* 39 (1984) at 1148, 1159; E. Sieh, "Prison Overcrowding: The Case of New Jersey," *Federal Probation* 53 (1989) at 41; B Walker and T. Gordon, "Health Risks and High Density Confinement in Jail and Prisons," *Federal Probation* 44 (1980) at 53. *See also* Joint Pls' Trial Ex. 27 *(Plata* Receiver's June 11, 2007 Supplemental Report on Overcrowding) at 3 (discussing increasing risk of "communicable disease outbreaks" in overcrowded CDCR units).

the health of the inmates confined within them and the public health.

[13] 30. As discussed in greater detail below, all of these features appear to be present in the CDCR at this time.

31. One striking feature of many of these characteristics of overcrowded systems is the manner in which they often operate in a feedback loop, with each problem reinforcing and heightening the impact of the other problems, making the problems much more severe much more quickly than would otherwise be expected. For example, it is well documented in psychiatric and social science literature concerning overcrowding that victimization and violence increase in overcrowded systems, due to less effective surveillance by understaffed correctional officers, the stressors of living in close quarters, and the stress on inmates caused by reduced access to programs and services.[2] As a result of this increase in victimization and violence, administrative segregation units tend to expand into overflow units. This produces several

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[2] *See* E. Mergargee, "The Association of Population Density, Reduced Space, and Uncomfortable Temperature with Misconduct in a Prison Community." The Governor also noted this overcrowding-related problem in his Declaration of a State of Emergency related to overcrowding. *See* Joint Pls' Trial Ex. 1 (Governor's 10/4/06 Proclamation Re: Overcrowding) at ¶ 2. The most recent annual CDCR report on incidents in 2006 also suggests that the increase in incidents may be due to the increased population pressure. *See* Joint Pls' Trial Ex. 7 (CDCR September 2007 Report, "Inmate Incidents in Institutions, Calendar Year 2006") at 2 (noting that "the rate of incidents per 100 average institution daily population increased from 8.7 in 2005 to 9.2 in 2006" and stating that "In 2006, the increase in the number of incidents could possibly be related to the increase in institutions and camps population.").

feedback effects. First, because administrative segregation units require additional staff to escort inmates to all of their appointments and to feed inmates in their cells, the expanded use of these units tends to exacerbate staffing shortages at the institution. Second, because overcrowded administrative segregation units provide less programming to inmates and take longer to process inmates out of the units, in my experience, more inmates in administrative segregation decompensate and require crisis care. Third, because overcrowded systems need to expand their administrative segregation units into "overflow areas," and because administrative segregation units often need to single cell a greater proportion of their population, the expansion of these units tends to exacerbate overcrowding in the rest of the prison. Similar effects take place in overcrowded reception center units, where inmates [14] are often locked for extended periods of time in conditions that resemble administrative segregation conditions. As I saw first-hand when I toured SVSP, many general population units in the CDCR today are frequently on a "lockdown" or "modified program" due to custody issues relating to violence and understaffing. Programs, activities, and mental health care are restrictted, delayed, or cancelled when this happens.

32. A similar feedback process takes place with respect to understaffing. Because overcrowded systems tend not to have enough staff and enough treatment space, inmates tend to have less access to needed medical and mental health care, ultimately creating a class of sicker prisoners who require more treatment staff than would otherwise be necessary. However, once this process has started, it becomes more difficult to recruit new staff members, who typically do not want to work in a system where they do

not have private office space or adequate spaces in which to provide treatment to their patients. In addition, because inmates whose mental illness goes untreated or under-treated are more likely to decompensate and incur disciplinary violations as a result, this problem also worsens the problem of expanding, staffing intensive administrative segregation units. The resulting increase in need for crisis mental health care also creates overcrowded crisis units, which cannot provide adequate care to inmates who decompensate under the pressures of overcrowding. This, in turn, leads to the placement of inmates who would ordinarily go to a crisis bed unit into "alternative" or "overflow" settings, such as administrative segregation units.

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[32] (b) *Evidence Concerning Overcrowding-Induced Constitutional Violations at the Individual Prisons I Visited.*

(i) Deuel Vocational Institute (DVI) Tour:

73. I toured Deuel Vocational Institute (DVI) on October 29, 2007.

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[33] *DVI's Practice of Housing Suicidal Inmates in its Administrative Segregation Units*

84. A serious overcrowding-related problem acknowledged by DVI in the September 19, 2007 Institutional Summary report to the *Coleman* monitors has to do with the use of administrative segregation cells instead of the infirmary for suicide-watch patients. The report states that:

> Another significant problem at DVI has to do with the increased use of medical beds in the OHU [or "outpatient housing unit," a name given to unlicensed CDCR infirmaries], most likely driven by ongoing Plata requirements. While the number of inmates referred to the OHU for acute mental health treatment has not increased, the number of beds that the mental health inmates have access to continues to decrease. As a result, we are frequently forced to overflow inmates to areas other than the OHU given the paucity of treatment space in our OHU. This has resulted in a significant increase of inmates being housed in Administrative Segregation, specifically K-wing pending a bed opening up in the OHU.

Coleman Pls' Trial Ex. 31 (DVI Institution Program Status from *Coleman* Tour Binder for 10/2/07 expert tour) at 2.

85. During my tour of DVI on October 29, 2007, staff confirmed this problem, reporting that although the 26-bed OHU used to be one-half designated for mental health cases, in recent months, only 4 of the 26 OHU beds are generally available to mental [34] health cases. At the time of my tour, there were 3 mental health inmates in the holding cells in the OHU, another 5 mental health patients in the OHU beds that are typically occupied by medical cases, and one inmate on suicide watch in the L-Wing administrative segregation unit. Staff stated it was very unusual that so many beds were available in the OHU for mental health patients. DVI staff reported that they have 11 cells in the L-Wing unit for OHU-overflow/suicide watch and that these cells are frequently used. This is remarkable because, in effect, the OHU is itself an overflow unit to the fully

licensed MHCB units. The administrative segregation overflow OHU is essentially an overflow unit to an overflow unit.

86. In my opinion, housing suicidal inmates in administrative segregation units, particularly ones as harsh, dirty and noisy as K-Wing and L-Wing at DVI, is a very dangerous practice, both because of its potential to exacerbate suicidal behavior, and because of its potential to discourage inmates from reporting their true feelings for fear of being housed in such a unit. Indeed, the dangerousness of these units is evident from the *Coleman* Court's Order that defendants undertake extensive modifications to their administrative segregation programs to increase monitoring of all inmates in these units to address the increased risks of suicide. *See* 6/8/06 Order at ¶ 1 (noting "escalating percentage of suicides occurring in administrative segregation units"). Although DVI is now using L-Wing in lieu of K-Wing, and L-Wing does in fact represent a slight improvement over the extremely harsh conditions of K-Wing, it is still an administrative segregation unit. Moreover, the cells in L-1 appeared to have been hastily retrofitted to be suicide-proof. They are also small and dirty, and the paint on the walls of the cells I observed was peeling badly.

* * *

[35] *Access to Higher Levels of Care at DVI*

88. Another problem underscored by DVI mental health staff during my tour of the institution on October 29, 2007 is their inability to access licensed Mental Health Crisis Bed (MHCB) units at other prisons for DVI's suicidal inmates. During the tour,

the Chief Psychiatrist, the Health Care Manager, and the Chief Psychologist all expressed to me that they are almost never able to transfer inmates needing higher levels of care to an MHCB unit or to one of the DMH inpatient programs.

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[36] *Medication Management Problems at DVI*

90. Another crowding-related problem discussed by DVI staff during my tour, and also documented in detail in the Special Master's Eighteenth Monitoring Report, is medication management. During my tour of DVI, Dr. Coppola, the Chief Psychiatrist, acknowledged serious problems with medication continuity and medication practices generally and stated that medication is a "major area where we need to make changes" to improve the delivery of care. During my tour, DVI staff also reported that due to large processing volumes of new inmates coming into the reception center, which typically number 100 new inmates a day, they are unable to check with counties when an inmate arrives reporting that he was on a medication that does not match documentation in the records from the sending county.

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[37] *Inadequate Medical Records at DVI*

93. During my tour of DVI on October 31, 2007, I visited the medical records in the OHU unit. Staff showed me an area where un-filed medical records are kept. In my estimation, there were between four and five feet of un-filed medical records. This kind of backlog of medical records is dangerous and unacceptable. Both medical and mental health clinicians

need to have up-to-date information in a patient's medical record in order to provide minimally adequate care.

94. During the tour, DVI staff also estimated that about one-third of the time when they meet with patients, they do not have access to the inmate's medical record during the clinical encounter. This is a dangerous clinical situation because staff does not have access to the patient's entire medical and mental health history, including such critical information as drug allergies, prior diagnoses and treatment history. Also, when staff enters clinical information on loose sheets of paper, there is a risk that important clinical observations will never make it into the permanent file.

* * *

[42] *The March 2007 Suicide of Coleman Class Member H at DVI Illustrates the Severe Consequences of Overcrowding-Related Problems:*

106. Several of DVI's overcrowding-related problems appear to have played a role in a successful suicide at DVI in the spring of 2007. In preparing this report, I reviewed the suicide report for *Coleman* Class Member H, who died on March 9, 2007. *See Coleman* Pls' Trial Ex. 26 (September 18, 2007 Suicide Report *Coleman* Class Member H and June 18, 2007 Executive Summary) at 5. *Coleman* Class Member H, a "severely mentally ill" schizophrenic, spent four days in CDCR custody prior to his death by hanging on Friday March 9, 2007 in the protective custody unit on West Hall. *Id.* at 2. [43] Although *Coleman* Class Member H reported to staff that he was taking psychiatric medications when he arrived

at DVI on March 4, 2007, he was not seen for an initial assessment by psychiatric staff or referred for an urgent medication evaluation by a psychiatrist as required by the *Coleman* Program Guide. *Id.* at 3, 5. He reportedly asked nurses and other staff members for his medications and told officers on several occasions that he needed to leave his cell. *Id.* at Suicide Report at 11.

107. The CDCR Suicide Report for *Coleman* Class Member H identified four serious failures that may have played a role in *Coleman* Class Member H's suicide. First, the Suicide Report notes that CPR was not initiated at the scene when custody staff discovered the inmate hanging in his cell. *Id.* at Executive Summary of Suicide Report at 5. In the course of the investigation into the death, it was revealed the Chief Medical Officer at DVI, who has since been suspended, personally countermanded CDCR policy by directing that custody officers should not conduct CPR at the scene when discovering a suicidal inmate, but should instead bring the individual to the institution's infirmary. *Id.* In my view, this serious problem is probably not related to overcrowding.

108. Second, when he arrived at DVI, *Coleman* Class Member H reported to staff that he was taking psychiatric medications. The jail transfer sheet failed to document his medications. However, DVI staff did not make any effort to verify his medication claim with the sending jail, and *Coleman* Class Member H was not seen within 24-hours by a psychiatrist for a medication review as required by the *Coleman* Program Guide. *Id.* at 5. Indeed, he was never seen by a psychiatrist during the four days he spent at DVI prior to his death. *Id.*

109. In my view, this second problem is related to overcrowding. During the tour of DVI, this issue was discussed with the mental health leadership and the screening nurse in R&R, who all indicated that given the huge volume of new arrivals each day and the limited space for processing staff, *DVI still does not have the resources to follow up on undocumented medication claims by calling county jails.* This is a serious problem. [44] The period immediately after an inmate arrives at jail or prison is a high risk period for inmate suicides, and this risk is exacerbated when inmates have gaps in medication.

110. A third problem documented in the Suicide Report and Corrective Action Plan for *Coleman* Class Member H is that *Coleman* Class Member H's mental health screening by a DVI psychologist was conducted at cell-front in the presence of *Coleman* Class Member H's cell-mate. The Suicide Report notes: "The cellmate may have been pressuring *Coleman* Class Member H, and may have influenced his responses. Furthermore, it is extremely difficult to observe an inmate while talking through the side of a solid door. This does not allow for an adequate clinical assessment." *Id.* at Suicide Report at 12. The author of the suicide report attempted to find out why these screenings were not taking place in a confidential setting, and received two possible explanations. The first explanation was that "custody staff was not cooperative with facilitating out of cell interviews for protective custody inmates due to the presence of non-protective housing inmates in that area at times." *Id.* at 5-6. In my experience, this type of difficulty with housing multiple categories of prisoners with special needs in a single housing unit is more common in overcrowded systems. The second explanation for the failure to conduct out of cell

screenings in the Suicide Report is that "[a]fter further inquiry, at the direction of the Chief Deputy, it became apparent that the mental health clinicians were not asking for inmates to be removed from their cells for interviews, in the interest of getting them done the day after their arrival to the institution (a local policy)." *Id.* at 6.

111. In my opinion, this third problem is also overcrowding-related. DVI is a busy, chaotic reception center that must manage a number of different populations, including a large protective custody population, a large mental health caseload, a significant population of disabled inmates, and a significant population of inmates with severe medical conditions. During the tour of DVI, staff reported that they often screen 100 new inmate arrivals five days a week. As the Receiver found in his report, this [45] churning of the reception center population due to overcrowding creates severe pressures on DVI's staff to cut corners in order to process all of the inmates in a timely manner. It appears that confidential out-of-cell mental health screenings have been sacrificed at DVI under the pressures of overpopulation.

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[45] (ii) California State Prison - Solano Tour

Solano Tour Overview

113. I toured California State Prison Solano ("Solano") on Wednesday October 31, 2007. According to the most recent CDCR population report dated October 24, 2007, as of midnight on October 24, 2007, Solano had a population of 6,051 and a design capacity of 2,610, for a population at 231.8 percent of capacity. Joint Pls' Trial Ex. 24 (CDCR Weekly Population Report, October 24, 2007).

Overcrowding in the H-Dorm at Solano

114. The overcrowding in H-Dorm at Solano (on the Level III yard) was severe and extremely disturbing. The dorm is a converted gym that Solano has filled with triple bunks due to the burgeoning population. While I was there, the dorm (and the rest of the prison) was on lockdown status, meaning that the majority of the inmates were physically in the dorm during my visit. It was noisy and chaotic, with multiple televisions playing at a high volume. Staff informed us that the dorm has a capacity of 226 inmates; there were 220 housed there during my tour.

115. The H-Dorm at Solano has been a source of great anxiety and stress for *Coleman* class members housed there. One CCCMS inmate who I interviewed during the tour *(Coleman* Class Member I) told me that he came "unwound" in the H-Dorm. He said he could not sleep, in part because of the dense population and in part because of the "constant, roaring engine of noise." His sleep deprivation became so severe that he [46] began to hear voices in the fans. Another class member, *Coleman* Class Member J, did not become a *Coleman* class member until he was housed in the H-Dorm. *Coleman* Class Member J also described severe sleep deprivation, which then caused him to become depressed and paranoid. He described the desperation he felt living in a very overcrowded dorm with no hope of moving out. Mental health staff recorded *Coleman* Class Member J's problems as "adjustment disorder" secondary to his housing unit. The housing conditions in places like the H-Dorm, where there is constant activity, sensory overload, extreme sleep deprivation and loss

of control, have been shown to cause or exacerbate mental illness. "Intensive Care Unit" (ICU) psychosis, a well-established clinical condition, for instance, is also caused by these conditions. As *Coleman* Class Member I and *Coleman* Class Member J demonstrate, people become extremely agitated, depressed, psychotic and potentially violent when living in these conditions.

Staph Infections:

116. I interviewed eight *Coleman* class members during my tour of Solano. Of the eight class members, two (*Coleman* Class Member K and *Coleman* Class Member L) had serious staph infections that Solano was treating with heavy doses of antibiotics. *Coleman* Class Member K, who was housed in the H-Dorm, told me that his staph infection caused an abscess on his arm, which medical staff drained earlier in the day. *Coleman* Class Member L was housed in Building 11. Another class member, *Coleman* Class Member M, told me that his cellmate also had a staph infection. Staph infections are a sign of poor hygiene, and they are a serious consequence of overcrowding that could grow more serious over time if these dorms and cells continue to be crowded with ill patients in the current manner. They can also become a threat to public health more generally, as antibiotics used to control these infections select for more treatment-resistant strains of the staph bacteria.

* * *

[50] 122. In my opinion, the medication problems at Solano are clear symptoms of overcrowding and understaffing. Effective mental health care depends on regular monitoring of medications for their effi-

cacy, the presence of side effects, and patients' compliance. In order to do this, doctors and medication dispensers must have manageable caseloads. Due to overcrowding and understaffing, Solano staff is not able to administer and monitor medications in an effective way. This problem is clearly documented in the Special Master's reports and was also apparent to me during the tour. The Special Master wrote in his 18th Report: "[n]early six months after the mental health caseload reached 1,550, 30 percent over its cap, access to treatment and the quality of mental health treatment were inadequate. Caseloads typically numbered 140 to 160." Joint Pls' Trial Ex. 36 at 83. Long pill lines, infrequent clinician contacts, and lapsed prescriptions are dangerous conditions that seriously undermine both mental health and medical care.

[51] (iii)Salinas Valley State Prison (SVSP) Tour

SVSP Tour Overview:

123. I toured Salinas Valley State Prison (SVSP) on November 1, 2007. SVSP is a Level IV high security institution located south of the city of Salinas in the Salinas Valley. According to the most recent CDCR population report dated October 29, 2007, as of midnight on October 24, 2007, SVSP had a population of 4,112 and a design capacity of 2,372, for a population at 173.4 percent of capacity. Joint Pls' Trial Ex. 24 (CDCR Weekly Population Report, October 24, 2007) at 2. Thus, in many respects, SVSP is less overcrowded than DVI, which is at 236.9 percent of design capacity according to the same report, and Solano, which is listed at 231.8 percent of design capacity. *Id.*

124. Nevertheless, there were significant overcrowding-related problems present in our tour of SVSP. During an initial meeting with the SVSP Warden and SVSP's clinical leadership for medical and mental health at the beginning of the tour, staff reported a number of relevant facts. Staff indicated that roughly 38 percent of the population at SVSP is mentally ill. Staff also indicated that 80 percent of the cases of suicidal ideation admitted to "holding cells" at SVSP do not result in an admission to the MHCB unit.

* * *

[55] *Suicide of SVSP CCCMS Coleman Class Member P Who Was Classified As a Medical Necessity Case:*

134. In the preparation of this report, I reviewed an internal CDCR Suicide Report and Corrective Action Plan, concerning the suicide of *Coleman* Class Member P at SVSP on November 5, 2006. *Coleman* Pls' Trial Ex. 24 (2/20/07 Suicide Report and Corrective Action Plan for Suicide of *Coleman* Class Member P). *Coleman* Class Member P had an extensive history of mental health treatment while in prison. *Id.* at Suicide Report at 2-7. According to the Suicide Report, *Coleman* Class Member P had at various points been on a *Keyhea* order for involuntary medication, and had been treated in the Psychiatric Services Unit at CSP-Sacramento for nearly two years between June 2001 and April 2003. *Id.* During this period, he had six crisis bed admissions for suicidal ideation and was admitted on two occasions to the acute inpatient psychiatric program operated by the state Department of Mental Health at the California Medical Facility in Vacaville. *Id.* He

arrived at SVSP in 2005 and was placed in the EOP program there. *Id.* He appears to have been discharged from the EOP program at SVSP because of his refusal to participate in treatment activities. *Id.* In May of 2005, his diagnosis was changed from an Axis I diagnosis to a diagnosis of "predominant Axis II characterological symptoms" and he was discharged to CCCMS and appears to have been continued on the CCCMS caseload as a medical necessity case. *Id; see also* Joint Pls' Trial Ex. 9 (September 2006 Program Guide) at 12-3-5 (CCCMS medical necessity standard). After he was made CCCMS, he continued to refuse treatment, although a clinician interviewed him on August 30, 2005 and concluded that he was exhibiting some psychotic processes. *Id.* He was referred to a psychiatrist medication line several times for possible initiation of antipsychotic medications, "but was never seen due to the shortage of psychiatrists, and no antipsychotic medications were prescribed for the inmate." *Id.* at 5. *Coleman* Class Member P finally saw a psychiatrist in late March of 2006 and he was prescribed an anti-anxiety medication. *Id.* at 6. In June of 2006, he was [56] continued in the CCCMS program on the basis of "medical necessity." *Id.* He repeatedly asked for Seroquel but was not given the medication. *Id.*

135. In my opinion, *Coleman* Class Member P appears to have been extremely mentally ill for someone in the CCCMS program based on medical necessity receiving treatment, and there appear to have been severe problems with access to psychiatrists and appropriate medication in his case. In May and June of 2006, he was treated at the CCCMS level of care while in the CCCMS administrative segregation program. *Id.* at 6. He was continued on CCCMS status through October of 2006. *Id.* at 7. On October

11, 2006, he apparently requested that he be removed from the caseload; and he was removed from the CCCMS program in a treatment team meeting on October 18, 2006. *Id.* On October 17, 2006, however, *Coleman* Class Member P was prescribed Effexor, a drug commonly used to treat depression and anxiety, although it is unclear whether he ever received this medication and it appears that the medication order may have been cancelled when he was removed from the caseload on October 18, 2006. *Id.* Inmates on psychotropic medications cannot be removed from the caseload pursuant to the Program Guide. *See* Joint Pls' Trial Ex. 9 (September 2006 Program Guide) at 12-3-13 (standards for removal from CCCMS caseload requires inmates not be on psychiatric medication). Nevertheless, he was removed from CCCMS care and placed in the stand-alone administrative segregation unit at SVSP on October 26, 2006. *Coleman* Pls' Trial Exhibit 24 (Suicide Report of *Coleman* Class Member P) at Executive Summary at 5. A court order in the *Coleman* case forbids the housing of caseload inmates in the stand-alone administrative segregation units used in the CDCR because of the harsh conditions there. *See* 10/10/02 Order.

136. In my opinion, this suicide reflects serious problems with the adequacy of diagnosis and treatment of chronically mentally ill inmates with serious mental health histories at SVSP. The case also reflects the serious consequences of some of the medication delivery problems I witnessed at SVSP, and the serious consequences of the [57] over-use of medical necessity diagnoses. If *Coleman* Class Member P had been maintained in the CCCMS program, he would have been seen more frequently and could not have been placed in the stand-alone administrative

segregation unit. Other overcrowding-related problems that have played a role in this suicide include the severe shortage of psychiatrists at SVSP, the medication distribution problems at SVSP, and improper removals of patients from the MHSDS program.

* * *

[58] *Problems With Access to MHCB Care and Other Higher Levels of Care at SVSP:*

140. I observed serious problems with crisis care for suicidal inmates while touring SVSP. It is clear that SVSP has a severe shortage of MHCB beds for its patients and that SVSP routinely employs a variety of make-shift "overflow" housing environments for such inmates. Dr. Chase, the CTC psychologist in charge of the MHCB unit, stated that the MHCB beds are always full. She indicated that inmates frequently stay in the MHCB unit for longer than the ten-day maximum mandated in the [59] *Coleman* Program Guide, especially if they are waiting for a placement in DMH. Joint Pls' Trial Ex. 9 (September 2006 Program Guide) at 12-5-1 (mandating maximum MHCB length of stay of 10 days). She also indicated that DMH can refuse referrals and sometimes does refuse referrals. She stated that generally the census is 5-8 MHCB patients and that in her experience working in the unit since May of 2007, up to 3 of the 8 MHCB beds are sometimes used by medical patients. She indicated that the unit refers cases to an outside MHCB unit at least once a week.

141. Dr. Chase also indicated that the institution uses a variety of overflow holding cells due to the

MHCB shortage. She indicated that three "dry cells," which are tiny freestanding upright cages with mesh wiring surrounding them (and no toilet) are routinely used during the day to house suicidal inmates. I observed these small holding cages on the tour of SVSP and they are extremely confined and are clinically inappropriate locations to assess suicidality and to have confidential psychiatric interviews with suicidal inmates. At night, these inmates are transferred into one of four holding cells outside the entrance to the CTC which are known as "wet cells" because they have toilets. SVSP also routinely uses "BPT cells" located on each yard for overflow suicide watch. This report was consistent with the findings of the Special Master in the most recent progress report. *See* Joint Pls' Trial Ex. 36 (18th Monitoring Report of the Special Master) at 153 (noting that holding cells "were in use daily and frequently housed inmates overnight. The holding cells in daily use were stand-up mesh cells. Holding cells used overnight were large group waiting rooms that had plumbing and that could be furnished with mattresses. . . . Standard CTC procedures resulted in heavy use of both types of cells and many overnight stays in large holding cells."). The MHSDS system never intended to permit the use of holding cells, particularly one where a patient is required to sit in a wire mesh holding cell without access to minimum health and safety standards. The use of these non-authorized, unlicensed "treatment settings" [60] results in an exacerbation of the underlying mental illness which led to the mental health crisis.

142. While in the MHCB unit, I spoke with *Coleman* Class Member R, a seriously mentally ill patient who has been waiting for referral to the Department of Mental Health acute inpatient program since

August 30, 2007. The Program Guide standard for transfer of an inmate to the acute DMH program at CMF is within 10 days of referral. *See* Joint Pls' Trial Ex. 9 (September 2006 Program Guide) at 12-1-13. Staff on the unit explained that *Coleman* Class Member R has chronic self-injurious behavior. He had been in a small safety cell near the front of the CTC unit since October 7, 2007, more than three weeks at the time of my November 1, 2007 tour, because he is too psychotic and paranoid to return to his cell – he believes that CDCR staff makes the floor vibrate in his MHCB cell and so he refuses to return to it. *Coleman* Class Member R is taking Depakote and Thorazine. He is alternately diagnosed as having Bipolar and Schizoaffective Disorders. His transfer has been delayed in part because he has 500 custody points, and must undergo a special review process before being sent to the acute DMH program at CMF. In my opinion, it is clinically inappropriate to keep this actively psychotic, paranoid inmate in a safety cell for such a long period of time. It is also inappropriate for him to remain in the MHCB unit for several months. He requires an expedited transfer to a higher level of care in DMH.

143. The difficulty of accessing higher levels of care was evident from my conversation with Dr. Chase, who stated that at one point during the summer the MHCB unit had a very sick homicidal inmate waiting for more than 100 days for a transfer to a higher level of care. She also expressed that in her opinion the general acuity level of her MHCB patients is extremely high, in part because of the difficulty of transferring cases to DMH care.

* * *

[67] 159. The documents that I reviewed indicate that the defendants do not anticipate being able to meet the need for mental health beds at every level of care until 2014, at best. The *Coleman* Special Master concluded in his Report filed September 24, 2007 that full implementation of defendants' latest proposed bed plan "will stretch out" to January 2014. *See Coleman* Pls' Trial Ex. 12 at 11. Moreover, the Special Master also noted that "objections to defendants' present and preceding bed plans on the part of plaintiffs, experts, special master and the Court all reflect a decade of accumulated experience and frustration that justifies fully concerns about CDCR's ability to generate and implement this latest plan effectively." *Id.* at 12. The Special Master further [68] suggests that actual implementation of defendants' bed plan may be unlikely to occur within a decade. *Id.* at 13.

160. While the Department is building its new facilities over the course of the next seven years, it presumably intends to continue to operate provisional units that do not meet full licensing standards for inpatient programs at Salinas Valley State Prison and the California Medical Facility. The D-5 and D-6 DMH intermediate inpatient treatment program units at SVPP and the P-2 and P-3 units at CMF are operating as interim intermediate care programs, and the court waived the licensing requirements so that they could meet the emergency overflow need for inpatient care beds. *See* 5/02/06 Order.

161. These units do not have the appropriate treatment space for mental health patients at this acuity, nor do they have the resources to provide yard and out-of-cell time in the appropriate manner. For example, in the SVPP D-5 and D-6 units, all mental

health treatment occurs on the dayroom floor. On October 18, 2007, the court ordered defendants to develop and submit proposals for developing "adequate mental health treatment and counseling space" at these SVPP and CMF units. 10/18/07 Order at 6:7-8.

* * *

[72] (3) *Improper "Overflow" Housing of Suicidal Inmates*

169. The problems with alternative, overflow housing arrangements for suicidal inmates was one of the most severe problems among many severe problems that I encountered in my tours. These problems also appear to be widespread, according to the most recent report of the Special Master. *See* id. at 326-27. The Special Master explains that this problem is an outgrowth of the MHCB shortage: "Inmates turned away from MHCBs are housed in alternative accommodations such as OHUs, MHOHUs and so-called holding cells, but these accommodations often do not afford the heightened level of treatment and observation that suicidal persons require. Worse yet, many inmates in these MHCB-alternative sites are never moved to actual MHCBs." *Id.* at 332-333. This was a serious problem at DVI, where suicidal inmates are routinely held in an overflow unit to the OHU unit (which is itself an MHCB overflow). Moreover, at DVI, this overflow was in its administrative segregation unit. The 18th Monitoring Report of the Special Master also notes that suicidal inmates were being placed in administrative segregation units at Mule Creek State Prison. *See id.* at 53 (MCSP using five cells in administrative segregation for inmates waiting for access to its MHCB beds).

170. The dangers associated with this type of alternative housing for suicidal inmates are clear. First, such arrangements discourage suicidal inmates from coming forward and seeking treatment. Second, such shortages discourage clinicians from making appropriate referrals to higher levels of care. There was nowhere for DVI staff members to send their acutely suicidal or psychiatrically decompensating inmates in administrative segregation and on suicide watch. As a result, DVI is forced to provide treatment at levels of care it is not staffed or licensed to provide — crisis level treatment to inmates in its EOP program, and longer term inpatient treatment to its OHU crisis bed patients. The Special Master's 18th Report included examples from various prisons around the state of inmates who were decompensating and not being referred to a higher level of care. *See, e.g.*, Joint Pls' Trial Ex. 36 (18th Monitoring Report of the Special [73] Master) at 220 (LAC: "Two inmates seen by the monitor's expert were acutely mentally ill in administrative segregation for weeks rather than being sent to higher levels of care (see Exhibit R, Case Reviews 2, 3)").

171. Documentation provided by defendants on a recent October 29, 2007 *Coleman* expert tour at CSP-Sacramento shows that even after that institution constructed a new, expanded unlicensed OHU, known as a mental health OHU (MH-OHU), the institution continued to rely on various ad-hoc "overflow" holding cells to house suicidal individuals experiencing a mental health crisis. *See Coleman* Pls' Trial Ex. 17 (October 5, 2007 Memo from CSP-Sacramento on Use of Alternative Sites for Crisis Bed Patients, produced to plaintiffs on October 29, 2007 *Coleman* tour). According to this report, between May 29, 2007 and September 28, 2007, CSP-Sacramento

used so called "ZZ beds" on 62 occasions, and used so-called "contraband cells" on three occasions when the institution's MHCB beds and two OHU units were at capacity. *Id.*

The Suicide of Coleman Class Member W at CSP-Sacramento in May of 2007 in an OHU Demonstrates the Dangerousness of Using These Units to House Suicidal Inmates:

172. The dangerousness of the use of alternative unlicensed OHU placements rather than MHCB beds is illustrated by the suicide in May of 2007 of *Coleman* Class Member W at CSP-Sacramento. The suicide also highlights several other serious care problems relating to overcrowding. *Coleman* Class Member W committed suicide on May 28, 2007 in an Outpatient Housing unit at CSP-Sacramento. *See* Coleman Pls' Trial Ex. 25 (August 2007 Suicide Report for *Coleman* Class Member W) at Executive Summary of Suicide Report at 1. He was 31 years old at the time of his death. *Id.* *Coleman* Class Member W had taken psychotropic medication in the community for five years and came into the CDCR with a diagnosis of Bipolar Disorder. *Id.* at 2. He had been hospitalized in the community a half-dozen times and had a significant history of suicide attempts, including jumping off a bridge. *Id.* He was noted to be on suicide [74] watch in the county jail at the time of his sentencing. *Id.* He entered the CDCR at the North Kern State Prison (NKSP) reception center on May 19, 2006 and was continued on Depakote and Seroquel, which he had been prescribed in jail. *Id.* He was initially placed at the CCCMS level of care. *Id.* at 3. A few months later, he was made EOP for a short

period of time after having had six admissions to the MHCB unit at NKSP for suicidality, but his EOP designation got "lost" and he was continued as a CCCMS inmate. *Id.* During his crisis bed admissions he was described as "extremely manic and psychotic with grave disability, including symptoms of confusion, disorganization, lability, flight of ideas, pressured speech, paranoia, irrational behavior, restlessness, confabulation and suicidal ideation." *Id.*

173. *Coleman* Class Member W was transferred to Folsom State Prison as a CCCMS inmate on January 23, 2007, after more than six months in the reception center at NKSP. *Id.* at 3. When he was transferred to Folsom, he was on Depakote, Seroquel, and Risperdal. *Id.* After some medication changes in February and March of 2007, his compliance with his medications dropped off dramatically. *Id.* On April 29, 2007, he was seen by a psychologist and counseled about the importance of medication compliance. *Id.* at 4. *Coleman* Class Member W was seen again on May 8, 2007 and his medications were changed. *Id.* He was seen again by a psychiatrist on May 21, 2004, was nervous and shaking, and complained about side-effects from his medication. *Id.* He was seen again by a psychiatrist on May 24, 2007, and reported that he had been feeling suicidal for one week and wanted to throw himself off the tier. *Id.* A suicide risk assessment was completed and his risk was noted to be high. *Id.* He was referred and transferred to a crisis bed at CSP-Sacramento. *Id.* However, after he arrived at CSP-Sacramento, he did not go to the MHCB. *Id.* Instead, he was housed in the Mental Health OHU and placed on suicide precautions. *Id.* The next day, May 25, 2007, a treatment team recommended that he be admitted to the MHCB unit. *Id.* However, he was never so admitted. *Id.* at 5. After

several days on a suicide precaution protocol that [75] only called for hourly checks, which violates CDCR policy, staff was preparing to discharge him when he was found hanging in his cell, on May 28, 2007. *Id.*

174. The Suicide Review for *Coleman* Class Member W concluded that "unwise" medication changes contributed to his problems. *Id.* It also concluded that once he was transferred to CSP-Sacramento, "[t]he standard of care was not adequate, as he was only given hourly checks and orders for more frequent checks were apparently disregarded. State policy requires checks at least every 15 minutes at staggered intervals. Had such frequent checks been done, the likelihood that he could have successfully completed an act of suicide would have been substantially decreased." *Id.* The Suicide Review also raised several other serious questions about his care, noting that he should have been referred to DMH for inpatient care from NKSP following his six crisis bed admissions. *Id.* at 6 (problem 2). The review also questioned his removal from EOP level of care, apparently through mistake. *Id.* at 3.

175. In my opinion, another serious question raised by the suicide is the decision to place an inmate with a very high risk of suicide and a history of serious suicide attempts into an unlicensed outpatient housing unit rather than admitting him to an MHCB unit. This inmate's level of dysfunction and his mental health history were such that staff should have recognized his need for crisis stabilization using medication changes and closely monitoring both his suicidality and his response to medication. This suicide also appears to raise serious questions about

medication management and the response to the inmates' medication side-effects.

(4) *The Impact of Overcrowding on Suicide Rates:*

176. Another potential indicator of the impact of overcrowding on the mental health of CDCR inmates is the current high rate of suicides in the CDCR. At least one [76] reputable study has linked overcrowding to increased rates of suicide.[3]

177. The suicide rate in the CDCR has been very high in recent years. The CDCR's own internal analysis of the suicide rate in 2005 found that the rate was 21.9 per 100,000, significantly above the national average for prisons of 14 per 100,000, as calculated by the Bureau of Justice Statistics. *See Coleman* Pls' Trial Ex. 16 (Defendants' 2005 Annual Report of Suicides) at 3. However, I am informed and believe that this rate does not include a number of additional deaths which plaintiffs contend were suicides. In any event, the suicide rate is significantly higher than the national average. In 2006, the CDCR reported a total of 43 suicides to plaintiffs counsel in e-mail notifications. *See Coleman* Pls' Trial Ex. 18 (Defendants' 2006 e-mail suicide notifications of suicides). According to CDCR population reports, the population of the CDCR in mid-2006 was 171,960. *See Coleman* Pls' Trial Ex. 37 (July 5, 2006 Weekly Population Report) at 1. Given that population, the 43 suicides in 2006 yields a suicide rate of 25 per 100,000 inmates — nearly double the national

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[3] *See* Meredith Huey and Thomas McNulty, "Institutional Conditions and Prison Suicide: Conditional Effects of Deprivation and Overcrowding" in The Prison Journal (December 2005) at 490.

average of 14 per 100,000. While suicide rates vary from year to year, the rates of suicide for 2005 and 2006 are very high, and a cause for concern.

178. As noted above, overcrowding increases both the prevalence and the severity of mental illness. Put another way, overcrowding both creates new mental illness and makes existing mental illness worse. Since many or most suicides are due to the presence of severe mental illness or the onset of a severe mental health crisis, it is clinically reasonable to anticipate a higher suicide rate in an overcrowded system. Another way to think about the correlation between overcrowding and suicide rates is to see overcrowding as a broad environmental factor increasing the risk of suicides by creating a larger class of at-risk individuals.

[77] 179. In my experience as a physician, suicidality is clearly correlated with the acuity level of a person's mental health condition. In a system where clinicians are forced to keep and treat inmates at lower levels of care than what is clinically appropriate due to the absence of adequate beds at higher levels of care, one would expect to see an increase in suicide rates. The Mental Health Service Delivery System that was developed to provide the full spectrum of mental health care to CDCR inmates was not designed to treat severely psychotic or seriously suicidal inmates in its lower levels of care.

180. Moreover, overcrowding creates surveillance and treatment failures among the population of potential suicides. Other problems present in the overcrowded CDCR today that a clinician would anticipate would create a greater risk of suicides are (1) inadequate clinical and custodial staffing, (2) inadequate medication practices, (3) the use of over-

flow cells and cages for suicidal inmates, and (4) over reliance on registry or contract mental health clinicians.

181. Another factor that may be responsible for the high rate of suicides in the CDCR is the high rate at which mentally ill individuals in the CDCR are confined to administrative segregation and other high-security units. Data provided by the defendants in this case demonstrates that somewhere between 29.3 percent and 46.6 percent of the inmates in administrative segregation units are mentally ill. *See Coleman* Pls' Trial Ex. 38 (June 8, 2007 CDCR Health Care Placement Unit Chart, showing that 46.68 percent of all inmates in administrative segregation are mentally ill; however, the figures in the chart for administrative segregation capacity are not added up correctly —the actual total capacity using the figures given for individual institutions should be 8,782, which yields a prevalence rate for mentally ill in CDCR administrative segregation units of 29.3 percent). The rate of mentally ill inmates in the higher custody Security Housing Units (SHUs) is even higher. The same chart shows that 40 percent of all inmates in SHU units are mentally ill. *Id.* (this Portion of the chart appears to be added [78] correctly). As noted above, administrative segregation and SHU units are dangerous for mentally ill inmates because such individuals tend to decompensate when they are isolated and locked in their cells for long periods of time and do not have adequate access to programs and exercise. In addition, the staff intensive nature of housing inmates in administrative segregation makes it extremely difficult to deliver treatment in these environments. Finally, it can be difficult to identify decompensation in these units because there are so few programming oppor-

tunities through which staff can observe the inmate's level of functioning.

182. The *Coleman* court and Special Master have recognized the dangerous nature of administrative segregation units for mentally ill individuals. On June 1, 2007, the *Coleman* court ordered defendants to develop further plans to reduce the risks of suicide in its administrative segregation and other high security units. *See* 6/1/07 Order at ¶¶ 4, 5. One issue included in defendants' plans to reduce the risks of suicide in these units is the development of 753 necessary walk-alone exercise yards in order to permit mentally ill inmates to have access to yard. *See Coleman* Pls' Trial Ex. 39 (Defendants' 10/29/07 Small Management Yard Plan). Defendants' new plan called for the construction of 476 walk-alone yards for administrative segregation inmates by January of 2010, even though the court ordered defendants to complete all of the necessary yards by "the end of fiscal year 2008/2009." 6/1/07 Order at ¶ 4 and 10/29/07 Small Yard Management Plan at 3.

183. The reasons given by defendants' for the delay in implementing this relatively straightforward project provides evidence as to the reason that defendants cannot address the underlying constitutional violations in this case without a remedy that addresses overpopulation. In their plan, defendants give the following reasons why they cannot meet the *Coleman* court's 24-month time frame: (1) there is no funding for the projects in this years budget, (2) the Government Code requires approval from the Department of Finance and the State Public Works Board for the projects, (3) a 45-day [79] notice period to the Joint Legislative Budget Committee is required, (4) the Public Contracting Code requires

competitive bidding for the projects, which is time-consuming, (5) the procurement process for the projects takes 23 weeks for some parts of the project and 33 weeks for some other parts of the project. *Id.* Defendants also noted that in the interim, they are unable to maximize the use of existing yards because of custody shortages. *Id.* at 3.

The Suicide of Coleman Class Member X illustrates Various Overcrowding-Related Care Issues as Well as the Dangers of Housing Suicidal Inmates in Administrative Segregation.

184. *Coleman* Class Member X committed suicide on January 18, 2006 in an administrative segregation unit at the Richard J. Donovan State Prison (RJD). *Coleman* Pls' Trial Ex. 27 (April 6, 2006 Suicide Report for *Coleman* Class Member X) at Executive Summary of Suicide Report at 1. Class Member X had never received mental health treatment in the community, but he received treatment previously while in jail and in the CDCR. *Id.* at 2. He arrived at RJD on October 3, 2005 with a diagnosis of Psychosis NOS and Mood Disorder NOS. *Id.* He had been treated at the jail with Seroquel. *Id.* When he was seen initially by a CDCR psychiatrist, he was prescribed a tapered dose of Seroquel for two weeks, and then taken off of medication. *Id.* On October 18, 2005, he suffered an apparent psychotic episode including delusions, auditory hallucinations, and paranoia. *Id.* One psychiatrist ordered a prescription of Seroquel for him by telephone. *Id.* Later that morning *Coleman* Class Member X told another psychiatrist who evaluated him that he was hearing voices telling him they were going to kill him. *Id.* He

was then placed into administrative segregation, apparently for safety concerns stemming from his statements that someone was going to kill him. *Id.* On October 19, 2005, he was evaluated by a psychologist and reported increased auditory hallucinations. *Id.* He also asked for a medication change. *Id.* On November 3, 2005, he was seen by yet another psychiatrist who continued him on the same medication, [80] Seroquel. *Id.* On December 6, 2005, he was seen by a third psychiatrist to whom he reported paranoid thoughts "such as thinking cellmate is poisoning food." *Id.* at 3. The psychiatrist diagnosed him with Psychosis NOS and increased his Seroquel dosage from 600 mg to 800 mg, however his medication administration record (MAR) for the month of December shows that he only received his medication on one or two days. *Id.* Apparently he was not placed on the mental health caseload during this entire period.

185. Despite his medication non-compliance, he does not appear to have been seen again by mental health staff until January 10, 2006, when he was given a mental health screening and placed in the CCCMS program for the first time. *Id.* There were numerous discrepancies in the inmate's medication records, but he appears to have been prescribed Quetiapine starting January 3, 2006. *Id. Coleman* Class Member X made multiple lacerations to his wrists on January 17, 2006. *Id.* He reported gambling debts. *Id.* No suicide risk assessment was conducted. *Id.* He was referred to custody staff who decided to re-house him into the administrative segregation unit pending an investigation into his claims concerning his gambling debts. *Id.* Mental health staff members in the administrative segregation unit were not aware of his self-injurious behavior. *Id.* The next day,

reportedly after being told by custody staff that he could be double celled, he was found hanging in his cell. *Id.*

186. The internal CDCR suicide review for this case found several serious problems with the manner in which his care was handled. *Id.* at 4-5. First, *Coleman* Class Member X's self-injurious behavior on January 17, 2006 was apparently not reported to mental health staff in the administrative segregation unit. *Id.* Second, the mental health clinician who evaluated *Coleman* Class Member X after he cut his wrists did not conduct a suicide risk assessment. *Id.* Third, he was never given an initial mental health screening when he arrived at RJD. *Id.* There was no documentation of the mental health evaluation he was allegedly given three months later on January 10, 2006. *Id.* Fourth, there were serious problems with medication administration records, and serious [81] discrepancies between the pharmacy medication records, Medication Administration Records, and medication orders in the inmate's medical record. *Id.*

187. Another serious issue noted in the Suicide Report is that the psychologist who evaluated *Coleman* Class Member X on January 17, 2006 and failed to conduct a suicide risk assessment did not have the inmate's health record available at the time of the interview. *Id.* at Suicide Report at 8.

188. In my opinion, this case illustrates a number of the problems and risks that a mentally ill patient faces in the CDCR today. First, the inmate was not properly screened for mental illness. Second, when he exhibited signs of psychiatric distress and suicidality, he was not appropriately responded to, was not given a suicide risk assessment, and in fact was placed into an administrative segregation unit, a dangerous

place for suicidal inmates. Third, when he complained about medication side effects, and when, according to his MAR, he stopped taking his medication for a month, he was not referred to a psychiatrist for an assessment. Fourth, his suicidal gestures were discounted, and his behavior was not reported to mental health staff members in administrative segregation who should have monitored him. Fifth, he was not appropriately assessed for placement in the mental health treatment program. These are the types of problems that take place in an overburdened, overcrowded system when staff does not have enough time with each patient and systems break down.

* * *

[84] 4. *Overcrowding is the Primary Cause of the Constitutional Violations in the CDCR*

196. These overcrowding-induced conditions that currently exist in the CDCR violate the rights of inmates to constitutionally adequate medical and mental health care. The conclusion that overcrowding is the primary cause of these violations is inescapable for several reasons.

The Persistence of the Constitutional Violations Present in the CDCR Demonstrates that They Are Caused by Overcrowding:

197. First, taken together, the range of Constitutional violations discussed above, including inadequate suicide monitoring and prevention, inability to timely access appropriate levels of care, inability to timely access mental health clinicians due to [85] staffing shortages, and inadequate medication management practices are unusual in a system that has

been under Court supervision for ten years. These serious, dangerous violations this late in the remedial process are typical indicators of a system plagued by severe overcrowding. In a non-overcrowded system, the Constitutional violations are more readily addressed by such interventions as increased staff and increased programming. However, in a system overwhelmed by crowding, these traditional remedies are woefully inadequate. This appears to be the case in the CDCR where remedial efforts have resulted in significant expansions of staffing and programming activities, yet the constitutional violations persist or even worsen.

The Coleman Special Master has found that overcrowding has undermined progress that was being made in various areas

198. The *Coleman* Special Master has observed that, although there was a period of time when it seemed that defendants might be making progress in terms of their bed plan and the provision of treatment, the overcrowding crisis has overwhelmed this hope. In his April 12, 2007 Report to the Court, he concluded: "By late 2005, it was evident that the reduction in population growth and then in the population itself in the first few years of the decade were over, and the numbers were rising fast. Early in 2006, defendants were staring at a galloping growth rate that threatened to hit 200 percent of capacity shortly, and the scramble was on to deal with the flow. One victim of the turnaround was CDCR's mental health plan." *See* 4/12/07 Special Master's Report on Defendants' Establishment of Interim Inpatient Intermediate DMH Beds at 8.

The Percentage of Caseload Inmates in the CDCR is Increasing Faster that the Overall Population:

199. Another factor that demonstrates that overcrowding is the primary cause of the constitutional violations is the fact that the percentage of caseload inmates in the CDCR is increasing faster than the overall CDCR population. Between January of 2003 [86] and July of 2007, the population of the CDCR grew from 159,743 to 172,897, an increase of 8.2 percent. *Coleman* Pls' Trial Ex. 34 and 35 (Monthly population figures downloaded from the CDCR website for January 2003 and July 2007). During the same period, the MHSDS caseload of EOP and CCCMS inmates grew from 24,599 to 32,039, an increase of 30.2 percent. *Coleman* Pls' Trial Ex. 36 (CDCR MHSDS Prevalence Data for January 2003 and July 2007 from CDCR Monthly Reports). Thus, during this period of roughly four and one-half years, the mental health caseload grew at four times the rate of increase for the overall population.

200. This is typical of systems where overcrowding is the primary cause of the constitutional violations because, as I have stated previously, overcrowding creates new mental health needs and exacerbates existing mental health needs. I encountered numerous examples of this on my various prison tours in preparing this opinion. As the data supports, the net result of overcrowding is a greater incidence of mental illness. In addition, this greater prevalence of mental illness presents at a more acute level. Traditional remedial efforts such as increased staffing will be insufficient to remedy this problem. Finally, as stated previously, overcrowding expands demand at the highest levels of care and creates

static backlogs of patients that make it difficult to assess the true demand for services.

In Many Instances, the Overcrowded Conditions Themselves Are the Cause of the Unconstitutional Mental Health Care:

201. The causal link between overcrowding and unconstitutional mental health care is clear and direct in the many CDCR housing units where space shortages from overcrowding directly result in long-term living arrangements that are harmful to the mental health of *Coleman* class members. For example, CCCMS inmates are routinely triple-bunked in chaotic, overcrowded dorms where they experience damaging levels of stress and fear of predation. It is clear that the mentally ill inmates I interviewed at [87] Solano who also had staph infections would not have been as ill if they were not living in overcrowded conditions. Similarly, mentally ill inmates are retained for extended periods in Reception Centers and in locked down general population units, where they are locked in their cells for most of the day and receive little or no programming or mental health services. Such environments add to the instability of mentally ill individuals. Another context in which the link is clear is improper placements in administrative segregation, where caseload inmates are often unable to access care and experience decompensation. Yet another context where this link between overcrowded conditions and constitutional deprivations is very direct is suicide watches in holding cells, cages, tanks, administrative segregation units, and other unsafe, unlicensed, and improperly supervised environments. These same harsh conditions, as discussed earlier, also increase the

demand for mental health services in prisoners in the general population who, in a properly operating, not overcrowded system, would not need mental health services. Isolation, seclusion, idleness, violence, fear and stress plague the prisoners in the CDCR as a direct result of overcrowding. These conditions exacerbate mental illness and are serious barriers to the provision of minimally adequate mental health and medical care.

202. There are a number of examples in the Special Master's Eighteenth Monitoring Report of overcrowding-related conditions directly interfering with access to constitutional mental health care. *See* Joint Pls' Trial Ex. 36 (Special Master's 18th Report) at 12 (Noting that at CSP-Sacramento, "[a]s predicted by staff, the expansion of EOP and PSU beds challenged the institution's ability to sustain previous levels of compliance. The amount of treatment provided to each EOP inmate was reduced, and more contacts were made at cell-front."); 84 (Solano: "rising caseloads, poor access to treatment associated with prolonged modified programming [lock-downs] in one yard, and ducat problems forced clinicians to resort too often to quarterly visits that were little more than a cursory check-in, many of which occurred at cell-front or in locations that compromised visual or auditory privacy. Under these conditions, a subset of sick inmates [88] got sicker, and clinicians sometimes missed, or failed to respond appropriately to, signs of mental illness."); 113 (Corcoran: "A high turnover rate among caseload inmates in concert with shortages of staff psychiatrists and lack of suitable treatment space continued to impede the delivery of mental health treatment and prevent CSP/Corcoran from meeting Program Guide requirements."); 126 (CSATF: "Large caseloads,

turnover, and long-term leaves combined to reduce compliance with Program Guide requirements. . . . Mental health staff response to referrals was often slow."); 127 (CSATF Administrative Segregation: "Case managers assigned to administrative segregation reportedly barely had time to complete weekly contacts."); 155-156 (SVSP CCCMS administrative segregation: describing "structural impediments" to delivering adequate care including inadequate staffing and space constraints.); 237 (CIM: In the administrative segregation units, a "work group to improve strained relationships between custody and mental health found that the problem was related largely to increased administrative segregation population and physical plant.").

B. *Opinion 2:* Other Remedial Efforts Will Not Succeed In Remedying The Underlying Constitutional Violations.

203. In my opinion, no other relief will remedy the underlying constitutional violations except a remedy which results in a substantial reduction in the prison population.

204. I am aware that the *Coleman* court has issued at least seventy-seven orders intended to induce the State to provide constitution levels of mental health treatment in the CDCR. The *Coleman* court concluded in its July 23, 2007 Order referring consideration of a prisoner release order to the three-judge panel: "Since February of 1996, this court has issued at least seventy-seven substantive orders to defendants in an effort to bring the CDCR's mental health care delivery system into compliance with the requirements of the Eight Amendment. Taken together, these orders [89] have contained directives aimed at all of the aforementioned requirements for a

constitutionally adequate mental health care delivery system. In addition, the Special Master and his staff have spent hundreds of thousands of hours working with the parties to develop program guidelines for a constitutionally adequate system and monitoring defendants' implementation of those guidelines. During the same period of time, the Special Master has filed seventeen semi-annual monitoring reports and fifty-five other reports reflecting the results of these efforts." 7/23/07 Order at 4:13-21.

205. Having worked as a correctional expert and having worked on the *Gates* and *Madrid* cases, I am very familiar with the monitoring team working for the court on the *Coleman* case. Moreover, having reviewed the recent monitoring reports and the other documents in this case, it is clear that very intensive remedial monitoring efforts have been going on in the *Coleman* case for many years. In my opinion, the large team of national experts working as court-appointed experts in the *Coleman* case has a great deal of collective experience working with troubled correctional systems. Nonetheless, after ten years of intensive monitoring and other remedial efforts, the CDCR remains plagued by serious constitutional deficiencies in its delivery of mental health care. I agree with the *Coleman* Special Master that the reason for this sorry state of affairs is that whatever tentative progress was made early on in this case has been overwhelmed by the massive population expansion in recent years.

206. From reviewing the docket in the *Coleman* case, I am aware that these more than seventy-seven orders have attempted to address issues of staffing, space, quality of treatment, and bed availability, among others. These include numerous orders

concerning such critical issues as adequate MHCB capacity (see, e.g., 1/15/01, 12/20/01, 10/8/02 Orders); access to DMH beds (see, e.g., 5/22/98, 7/26/99, 8/28/00, 4/4/01, 6/27/01, 3/4/02, 5/7/02, 10/8/02, 1/19/04, 7/9/04, 6/30/07 Orders); and staffing (see, e.g., 2/17/96, 6/17/98, 8/25/99, 1/19/99, 7/26/99, 1/13/00, 4/27/00, 8/28/00, 6/13/02, 10/8/02, 3/3/06 Orders).

[90] 207. Persistent shortages of beds at every level, lack of adequate mental health and custodial staff, and inadequate treatment and programming space clearly reflect the overcrowding crisis. In my opinion, more orders by the Court along these lines of those discussed above will not remedy the underlying Constitution violations at this time. The system is simply too overwhelmed by the population for these orders to be effective as long as the population continues to remain at current levels.

208. I am also aware that the State has proposed construction of new prisons and re-entry facilities as the bulk of its solution to the overcrowding crisis. I have reviewed the Receiver's analysis in his Reports regarding overcrowding and the further demands for mental health and medical staffing, and treatment space that building these new prisons and re-entry facilities will create. As the Receiver notes, building more prisons and re-entry facilities will require additional staff, and will spread existing overtaxed staff among more facilities. See Joint Pls' Trial Ex. 26 (Receiver's 5/15/07 Report Re Overcrowding) at 40-41. The building timeline for the beds contemplated by AB 900 does not anticipate any new beds until 2009, and most of the beds will be built much later. *See Coleman* Pls' Trial Ex. 40 (January 2007 CDCR Estimated Construction Schedule for Infill Bed Plan,

Ex. 20 to Receivers 5/15/07 Report). Moreover, as the delays associated with the CDCR's plans to construct walk-alone yards demonstrate, construction projects involving government agencies are rarely finished by the anticipated dates. In my opinion, any added capacity for mental health and medical treatment that this prison construction may create will take far too long to be sufficient as a remedy to the current constitutional violations, which are extremely urgent and life-threatening. This plan also fails to address the other persistent, intractable overcrowding-related problems that are present in the CDCR, such as clinical and custody shortages, adequate medication management practices, and sufficient beds at the highest levels of care.

[91] 209. Similarly, the alternative remedy proposed by defendants for beds at the MHCB and inpatient level will not be finished until 2014 — seven years from now — at the earliest, even assuming there are no bureaucratic delays or construction delays. *See Coleman* Plfs. Trial Ex. 12 (9/24/07 Special Master's Report on Defendants' August 2007 Bed Plan). That plan is unacceptable. Mentally ill *Coleman* class members are daily suffering dangerous denials of mental health care and medical care that place them, their fellow inmates, the officers who supervise them, and the public at risk. In the interim, the only way to correct the endemic denials of appropriate mental health care that currently exist in the CDCR is to significantly reduce the population. No other remedy will result in a constitutional mental health care system in the CDCR.

Dated: 11/9/07 /s/ PABLO STEWART, M.D.
PABLO STEWART, M.D.

IN THE UNITED STATES DISTRICT COURTS FOR
THE EASTERN DISTRICT OF CALIFORNIA AND
THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED
OF THREE JUDGES PURSUANT TO SECTION
2284, TITLE 28 UNITED STATES CODE

No. Civ S 90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 THE
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

SUPPLEMENTAL EXPERT REPORT OF PABLO STEWART, M.D.

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* * *

[2] 9. In the months since I completed my prior report for this case, the *Coleman* Special Master issued a final 19th monitoring report for tours conducted between March and [3] early June of 2007 and a draft 20th round monitoring report for the monitoring period of September 2007 through February of 2008. The *Plata* Receiver also issued his 7th and 8th quarterly reports regarding the status of the healthcare system in the prisons, dated March 14, 2008 and June 17, 2008 respectively. I reviewed these documents, and others, in order to update my opinions in this matter. A complete list of the materials I have reviewed, including the updated materials I reviewed for this supplemental report, is attached hereto as *Appendix B*.

10. My opinions are also based on the site inspections I completed back in October and November of 2007 and, more recently, in late July and early August of 2008. Specifically, I toured the following institutions on the following dates: Deuel Vocational Institute (DVI) (October 29, 2007); California State Prison-Solano (Solano) (October 31, 2007); Salinas Valley State Prison (SVSP) (November 1, 2007 and July 29, 2008); California Medical Facility (CMF) (July 30, 2008), and; Mule Creek State Prison (MCSP) (August 1, 2008).

11. During each of the site inspections I conducted, staff provided me with excellent access to information, clinicians, housing areas, treatment spaces and to prisoners and their medical and mental health records. I also was accompanied by a photographer on some of my recent tours and was able to have photographs taken when I or the accompanying attorneys so requested. Custody and clinical staff, including both medical and mental health clinicians, made

themselves available throughout the day and answered questions about existing conditions, problems, plans for the future and challenges. The institutions also provided requested documents for each tour, including information such as logs of patients transferred to (or awaiting transfer to) higher levels of care and printouts showing *Coleman* class members by housing unit. Various pictures from my tours are attached as follows:

Appendix C	Mesh, holding cages in the Salinas Valley State Prison Correctional Treatment Center (CTC)
Appendix D	Mental Health Outpatient Housing Unit Cells at Mule Creek State Prison
Appendix E	Gym Dorm on B-Yard at Mule Creek State Prison
[4] Appendix F	Gym Dorm on A-Yard at Mule Creek State Prison

II. SUMMARY OF MY OPINIONS IN THIS MATTER

12. As set forth in detail below, it is my opinion that there has been no material change in the conditions of severe overcrowding in the California prison system in the past eight months since I issued my prior report. In particular, it remains my opinion that overcrowding is the primary cause of the constitutional violations currently experienced by *Coleman* and *Plata* class members, that the State must reduce the population (including *Coleman* class members) if it has any hope of addressing those violations and that such reductions can be done safely.

13. Although my report details several deficiencies in the medical and mental health care systems that I believe are the direct result of overcrowding, the following are the systemic problems that I find most disturbing and that, in my opinion, have the most detrimental effects on the *Coleman* and *Plata* classes:

- *The Coleman class, as a whole, is more acutely ill due to the extreme shortage of beds at every level of care.* This is particularly true for class members in need of acute hospitalization, but the shortages affect the entire Mental Health Services Delivery System (MHSDS). By denying prompt access to inpatient care, the State is allowing patients to become more acutely ill than they otherwise would. By the time those patients reach an inpatient bed, they will generally require more resources for a longer period of time to become well than they otherwise may have needed. This further backlogs the system, thereby exacerbating the shortage of beds and making it difficult to assess the true demand for services.

- *The medication management system is overwhelmed and the State is therefore unable to adequately monitor both the efficacy and the side effects of prescribed medications.* I saw this problem time and again on my tours. Because of staff shortages, frequent lockdowns, overwhelmed pharmacies and medical records offices, and the vast number of patients on medications, staff spend only a few seconds with each patient [5] when they distribute medications. Too many clinical contacts occur at cell front, in makeshift "offices" or in the open with no confidentiality, without access to medical records and by clinicians with little or no ongoing relationship with their patient. Problems such as side effects, refusals and unrelieved symptoms are regularly not identified, reported or followed up on with psychiatric appointments or blood testing. Continuity of care is hampered by staff turnover and major reliance on contract and registry clinicians. The ability to appropriately monitor both the efficacy and the effects of medication is a key component of basic psychiatric and medical care.

- *Until overcrowding is reduced, the State will be unable to hire and retain adequate, qualified and permanent staff.* As detailed below and as explained in the *Coleman* Special Master and the *Plata* Receiver's reports to the Courts, many medical and mental health staff face significant challenges in the current overcrowded system, including inadequate office and treatment space, insufficient inpatient beds, and large caseloads. These are difficult working conditions that, in my opinion, hamper the State's ability to hire and retain permanent and qualified staff.
- *The overcrowded conditions themselves significantly burden the medical and mental healthcare systems.* Because of population pressures, inmates are frequently housed in places that either exacerbate or, in some instances, might trigger mental health symptoms, including crowded dorms, administrative segregation units, holding cages, and small cells that were built for one person, but

currently hold two. These conditions put added pressure on the already over-burdened medical and mental health systems.

- *The overburdened system results in a suicide rate that is nearly twice the national average.* The *Coleman* Special Master found in his analysis of 2006 suicides that more than 70 percent were "foreseeable and/or preventable." Joint Pls' Trial Ex. 58 at p. 2. In my opinion, the high suicide rate is a direct result of overcrowding in that the system lacks beds at every level of care, is plagued with poor medication management practices, and has severe shortages of adequate and permanent staff.

[6] III. MY OPINIONS IN THIS MATTER

A. *Opinion 1*: Overcrowding Within The CDCR Is The Primary Cause Of The Constitutional Violations Currently Experienced By *Coleman* And *Plata* Class Members.

14. My previous report detailed the characteristics that are typically seen in overcrowded correctional settings, including shortages of medical, mental health and correctional staff, insufficient treatment space in which to provide therapeutic activities and contacts, dangerous and chaotic living conditions, increased idleness among prisoners due to decreased programming, increased population pressures on reception centers and locked areas such as administrative segregation units and delayed access to higher levels of care. All of these characteristics, particularly when they are permitted to go on for long periods of time, significantly increase the burden placed on

mental health and medical systems.[1] I have personally witnessed these conditions in California's prisons and am also aware that they are well-documented by others with intimate knowledge of California's system, including the Governor, the federal Receiver who oversees the medical care system and the Special Master in the *Coleman* case.

15. The facilities and conditions I have observed in the California Prison system represent the most overcrowded conditions I have seen. In this report, I first set forth the findings from my late July and early August 2008 tours at SVSP, CMF and MCSP. I have also provided updated information about facilities I did not return to during my recent round of inspections. Finally, I discuss my overall opinions in this case based on my prior report, my [7] updated tours of these facilities and my review of additional materials and documents identified in Appendix B.

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[1] *See* P. Paulus, G. McCain, V. Cox, "The Relationship Between Illness Complaints and Degree of Crowding in a Prison Environment," *Environment and Behavior* 8 (1976) at 283, 288; P. Paulus, G. McCain, V. Cox, "Death Rates, Psychiatric Commitments, Blood Pressure, and Perceived Crowding as a Function of Institutional Crowding," *Environmental Psychology and Nonverbal Behavior* 3 (1978) at 107, 115; V. Cox, P. Paulus, G. McCain, "Prison Crowding Research," *American Psychologist* 39 (1984) at 1148, 1159; E. Sieh, "Prison Overcrowding: The Case of New Jersey," *Federal Probation* 53 (1989) at 41; B Walker and T. Gordon, "Health Risks and High Density Confinement in Jail and Prisons," *Federal Probation* 44 (1980) at 53. *See also* Joint Pls' Trial Ex. 27 (*Plata* Receiver's June 11, 2007 Supplemental Report on Overcrowding) at 3 (discussing increasing risk of "communicable disease outbreaks" in overcrowded CDCR units).

1. Evidence Concerning Overcrowding-Induced Constitutional Violations from My Recent Prison Inspections

(a) *Salinas Valley State Prison (SVSP) Tour*

SVSP Tour Overview

16. I toured Salinas Valley State Prison (SVSP) on November 1, 2007 and again on July 29, 2008.

* * * *

[8] *Long Waiting List for Intermediate Care Facility Beds*

19. DMH staff reported during the tour of SVSP that the current waiting list for the level IV ICF beds was at 171 patients. This waiting list is system-wide and has been a constant source of concern by the *Coleman* Special Master.

20. The extremely long waiting list for ICF beds has a ripple effect throughout the system.[2] Sterling Price, the Acting Executive Director of DMH who attended both my Salinas Valley State Prison and my California Medical Facility tours, acknowledged that some of the inmates on the SVPP waiting list for ICF beds have been on the list since 2005. This is consistent with the reports from psychologists at both SVSP and CMF who said that it can take up to a year for a patient to come off of the waiting list. Dr. Kittimongcolporn, the Clinical Director of the MHCB unit at SVSP, reported that it takes a year or longer to get her patients to an ICF bed and that she does

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[2] SVSP staff reported that construction of another 64 bed ICF unit is on schedule for completion later this year. These beds, while badly needed, will still fail to address the serious shortfall of beds.

not typically refer patients to those beds for that reason. Dr. Burkhardt, a psychologist at SVSP who previously worked as the Clinical Director of the CTC, also reported a 9-12 month wait for ICF beds. When I asked Dr. Burkhardt whether she continues to refer patients to that list, she said that she really only refers lifers who are at the EOP level of care since those patients will be around long enough to wait for a bed. The *Coleman* Court also recognized the problem of under-referrals in its June 28, 2007 Order:

> [9] "Indeed, from other sources the court has learned that at least some CDCR clinicians have stopped referring patients to DMH because of its refusal to accept referrals." 6/28/07 Order (Docket 2301) at 3, fn. 2.

21. The impact of such a long waiting list for essential inpatient beds cannot be overstated. When psychologists and psychiatrists face waiting lists of 9-12 months, they inevitably will stop referring patients to those beds, as Dr. Burkhardt and Dr. Kittimongcolporn confirmed. This is because the referral becomes an exercise in futility for the already over-burdened mental health staff, particularly if the referrals involve patients who are paroling soon. As a result, patients will parole without receiving the appropriate mental health care and are more likely to return to their home communities in less stable conditions. This, in turn, will increase the demand on the limited parole and community mental health services and increase the likelihood that the patient may reoffend and be returned to the prison system. Overcrowding is a tremendous obstacle to CDCR's ability to address the cycling of persons with serious mental illness from parole to prison.

22. Data associated with the recent addition of 50 mental health crisis beds at CMF also suggests that clinicians have been under-referring patients for crisis care. Whereas referrals to MHCBs ranged from 276 to 298 between March and May of 2008, they jumped to 355 in June, the month that the new beds opened. Coleman Pls' Trial Ex. 137. It is possible that this surge in referrals, which represents the highest number of referrals since at least November of 2006, resulted not from a greater rate of crisis incidents, but rather from the realization among clinicians that crisis beds were now available. That is, clinicians previously identified the patients, but did not refer them to MHCB because the resource was simply not available.

Waiting List for Acute Inpatient Beds

23. Sterling Price reported that the waiting list for the acute psychiatric hospital at CMF was 15 as of July 29, 2008 but that it was up to 45 patients as recently as July 1, 2008. I heard reports from staff members at SVSP and CMF that it takes anywhere from about two to [10] eight weeks to get a patient into an acute bed. SVSP also listed access to acute beds as a problem in its *Coleman* 21st Round Corrective Action Plan, dated May 23, 2008: "We continue to experience difficulty with the continual wait list for our referral to DMH acute for any referral reason. Length of wait has also been longer for self injurious behaviors and suicidal ideation. We had one inmate who was referred for grave disability reason at an acute level that we decided to send [] back to EOP to wait for intermediate level of referral so that he at least could program there while waiting." Coleman Pls' Ex. 138 at p. 7.

24. This backlog is particularly significant in an overcrowded system like the CDCR's. Dr. Kittimongcolporn, the Clinical Director of the CTC at SVSP, told me that if she refers a patient to an acute bed from a mental health crisis bed (MHCB), that patient stays in the MHCB until he is transferred. While it may be clinically appropriate (and even necessary) for a patient to remain in an MHCB while he awaits transfer, it also means that that patient is occupying a bed that is in high demand for other acutely ill and suicidal patients. This puts clinicians in the dangerous position of having to triage the mental health acuity of their patients because they simply do not have enough options for adequate treatment.

Problems with Access to MHCB Care at SVSP

25. The Special Master has documented system wide shortages of MHCBs repeatedly, including in his 20th round report: "There continued to be too few MHCBs to accommodate CDCR's mental health population. Inadequate capacity was exacerbated by delayed access to DMH and EOP programs, as needed MHCBs were too often filled with decompensated or fragile inmates waiting weeks and months to be transferred to an appropriate level of care. The ongoing challenge to find beds for inmates with chronic, long-term medical conditions regularly reduced MHCB capacity at CSP/LAC, HDSP, MCSP, and SVSP." Joint Pls' Trial Ex. 57 at p. 351. As a result of these severe shortages, institutions are forced to house acutely mentally ill patients in settings that are cruel and inappropriate for crisis care:

> [11] As a result of the scarcity of MHCBs throughout the system, institutions continued to resort to the use of alternative beds to house

> inmates pending MHCB transfers. These alternative locations were uniformly inappropriate for acute care. Throughout the monitoring period, inmates were admitted to alternative areas for stays lasting longer than 72 hours. Many of them had multiple admissions. Inmates who might have been clinically considered for DMH levels of care if they had been admitted to MHCBs were not given that consideration. Complete and reliable data regarding the locations and uses of these alternative cells was rarely available.

Joint Pls' Trial Ex. 57 at p. 352.

26. My prior report documented the serious problems I saw at SVSP with respect to suicidal inmates' impeded access to mental health crisis beds and consequent placements in wholly inadequate alternative settings. *See* 11/19/07 Report at pp. 58-60. These problems, including a shortage of sufficient mental health crisis beds and the use of make-shift cages to hold patients waiting for crisis beds, existed during my July 29, 2008 tour as well. Dr. Kittimongcolporn, the Clinical Director of the CTC at SVSP, reported that the MHCBs are almost always full. The Chief Psychiatrist, Dr. Wilson, explained that he has to "fight" to maintain the 6-8 MHCBs so that medical patients are not placed in those beds. While the MHCB unit at SVSP is theoretically open to other institutions, staff reported that only "very rarely" is anyone outside of SVSP admitted to the unit, although it did happen the week before the tour.

27. During my tour on July 29, 2008, I observed again the dry holding cages that SVSP must use when there are no available mental health crisis beds. I described these cages and the wet cells used for overnight stays in the CTC in my prior report:

Dr. Chase also indicated that the institution uses a variety of overflow holding cells due to the MHCB shortage. She indicated that three "dry cells," which are tiny freestanding upright cages with mesh wiring surrounding them (and no toilet) are routinely used during the day to house suicidal inmates. I observed these small holding cages on the tour of SVSP and they are extremely confined and are clinically inappropriate locations to assess suicidality and to have confidential psychiatric interviews with suicidal inmates. At night, these inmates are transferred into one of four holding cells outside the entrance to the CTC which are known as "wet cells" because they have toilets. SVSP also routinely uses "BPT cells" located on each yard for overflow suicide watch. This report was consistent with the findings of the Special Master in the most recent progress report. *See* Joint Pls' Trial Ex. 36 (18th Monitoring Report of the Special Master) at 153 (noting [12] that holding cells "were in use daily and frequently housed inmates overnight. The holding cells in daily use were stand-up mesh cells. Holding cells used overnight were large group waiting rooms that had plumbing and that could be furnished with mattresses . . . Standard CTC procedures resulted in heavy use of both types of cells and many overnight stays in large holding cells."). The MHSDS system never intended to permit the use of holding cells, particularly one where a patient is required to sit in a wire mesh holding cell without access to minimum health and safety standards. The use of these non-authorized, unlicensed "treatment settings" results in an exacerbation of the

> underlying mental illness which led to the mental health crisis.

11/9/07 Report at pp. 59-60.

28. During my tour on July 29, 2008, I spoke with *Coleman* Class Member SSS, an inmate who was waiting in one of the stand-up, mesh holding cages for admission to a crisis bed. Logs in the unit showed that *Coleman* Class Member SSS was admitted to the crisis bed unit the previous day, but was still waiting for placement. He was moved from the dry holding cage to a wet cell at 7:15 p.m. the night before and was back in the dry holding cage as of 8:15 a.m. the following morning. Staff reported that while *Coleman* Class Member SSS would be admitted within 24 hours, other inmates sometimes wait several days for admission, particularly on the weekends. A Psychologist on C-Facility, for instance, reported that patients often stay in the dry holding cells (with moves to the wet cells in the evenings) from Friday to Monday if they need crisis care on the weekends. This is consistent with the data SVSP provided to the Special Master for his 21st monitoring round showing that of the 80 referrals made to MHCBs between November of 2007 and April of 2008, 45 (56 percent) were admitted on the same day, 24 (30 percent) were admitted within 1 day, 5 (6 percent) were admitted within 2 days and 6 (8 percent) were admitted in 3 or more days. Coleman Pls' Trial Ex. 138 at p. 6.

29. The stand-up, mesh holding cages are not clinically appropriate places to house patients who are having mental health crises. Pictures of the cages from my tour are attached to this report as *Appendix C*. Staff informed me during the tour that they cannot utilize wet holding cells for those patients during the day, however, because they have to use

those cells to hold inmates awaiting medical appointments. This is another example of medical and mental health staff competing for very limited space in medical and mental health systems that simply [13] cannot accommodate the large volume of patients. To treat a patient in crisis as if he was a dangerous animal, subjecting him to public degradation and humiliation, is, by definition, inappropriate mental health care. The routine use of these cages throughout the system for mental health interventions is itself a tragic symptom of an overcrowded and dangerous system where mental health staff are taught to be fearful of their patients and inhumane practices are not only tolerated, but institutionalized within the medical and mental health systems.

* * * *

[16] (b) *California Medical Facility (CMF) Tour CMF Tour Overview*

39. I toured California Medical Facility (CMF) on July 30, 2008, although I also visited the prison many times between 1990 and 2000 when I was monitoring the *Gates* consent decree as a medical and psychiatric expert.

* * * *

[17] *Access to Higher Levels of Care*

41. The Special Master has repeatedly reported on the very limited access to DMH inpatient beds, including most recently in the draft 20th report: "DMH acute care resources for male inmates consisted of 130 beds at CMF and 25 beds at ASH, the latter of which re-opened to admissions in July 2007. Slow access, coupled with a growing wait list and increasing numbers of rescinded referrals, made it

clear that these resources could not adequately accommodate CDCR's expanding mental health population." Joint Pls' Trial Ex. 57 at p. 349. The Special Master also collected data about referring institutions during the 20th round in order to detail the delayed access to care:

> Of the 18 prisons that referred inmates to the acute programs at CMF and ASH, 13 reported delayed access. The most commonly cited cases, and the longest delays, were associated with referrals involving acutely psychotic inmates who were not suicidal. Such referrals, considered low priority, were routinely placed on a wait list and commonly rescinded by the institution. Other referrals, involving inmates within 30 days of parole and inmates without parole dates, were denied in accordance with DMH policy. Consequently, a large number of referrals failed to result in transfer, despite a low rejection rate. The percentage of acute care referrals that resulted in transfer was 40 percent for CSP/Sac, hovered around 50 percent for CMC and RJD, and barely exceeded 60 percent at DVI and WSP.

Id. at pp. 349-350. In my opinion, DMH's practice of designating acutely psychotic but non-suicidal patients as "low priority" admissions to acute beds is a direct consequence of [18] overcrowding. Clinicians would not be forced to turn acutely psychotic patients away at the door in a system that had sufficient inpatient beds.

42. Sterling Price, the acting Director of DMH Programs at SVSP and CMF, reported that the ICF waitlist for level IV beds was up to 171 patients and that the acute waiting list was 15 as of July 30, 2008, but had been as high as 45 on July 1, 2008. I visited

the S2 unit (among others) during the tour, which currently has 20 mental health crisis beds for use by CMF inmates and 10 acute beds that are available to the entire system. Mr. Price reported that the unit had 37 referrals in June of 2008, but had a high of 52 referrals back in December of 2007. When beds are not available in this, and presumably other units, Mr. Price reported that referred inmates either stay in their EOP units or go to observation cells. As I heard from staff at SVSP as well, referrals on the weekend are especially hard due to limited staffing during that time. This information is consistent with the Special Master's general findings that there is poor access to acute and intermediate care facility beds in this overcrowded system.

43. The insufficient access to higher levels of care has created a system which is overwhelmed by the acuity of its patients at every level of care. EOP units house many patients in need of inpatient care, MHCB's house patients in need of inpatient hospitalization, intermediate care facility units house many patients in need of acute hospital care and so on. When and if these patients finally reach the level of care they require, their mental health conditions may be far more serious, resulting in longer stays and more resources in order to stabilize and get well.[4]

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[4] It is also apparent from the chaos of the system that the inverse problem happens—patients sometimes stay in *higher* levels of care than they require due to the logjam in the system. The Monthly Bed Utilization Report for the DMH Hospitals and Psychiatric Programs for June 2008, for instance, lists eight patients who are currently housed in acute beds while they wait for an ICF (a lower level of care) bed to open. *Coleman* Pls' Trial Ex. 118, Patients 608, 658, 670, 673, 694, 696, 759, and 760.

44. My interview with *Coleman* Class Member TTT illustrates some of these problems. I interviewed Class Member TTT in the S1 unit at CMF, which houses men with [19] acute mental illness. Although Class Member TTT had been housed in the acute unit for nearly six months at the time I saw him, he was floridly psychotic, with unintelligible thought processes. According to his file, he was prescribed a 300 mg. daily dose of Clozaril, which I refer to as the "atomic bomb" of antipsychotic medications because it is a medication of last resort that has the potential to effectively shut off a patient's bone marrow if it is not very closely monitored with weekly or bi-weekly blood draws. Class Member TTT demonstrates the very severe acuity of some *Coleman* class members in that he continues to display active psychosis even after 6 months of acute care, including treatment with very powerful anti-psychotic medication. It was also apparent to me that he will require an acute level of care for a long period of time, thereby consuming a very valuable resource within the CDCR's overcrowded system. According to the DMH Monthly Bed Utilization report, he also waited at MCSP for nearly a month (between 1/8/08 and 2/6/08) for an acute bed. *Coleman* Pls' Trial Ex. 118, Patient 127.

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[21] *Insufficient Office and Treatment Space*

49. CMF also struggles with serious space issues. It is an old-style prison that consists of a series of long, narrow units that run perpendicular to the main corridor. The prison was constructed at a time when there was no inclusion of treatment space or even offices for staff. As a result, treatment space is very limited and staff members frequently have to juggle their schedules and patients in order to com-

plete groups, case manager contacts and other client contacts. I observed these problems first-hand in several units at CMF. In the S1 unit, for instance, staff explained that they use the same single room for treatment team IDTTs, case manager contacts, psychological testing, all patient groups and to conduct admissions into the unit. As we moved throughout other DMH units, we learned that these severe space restrictions are common in nearly every unit off the main corridor, including in S2 (which has 30 MHCB and acute beds), Q2 (which has 30 acute beds), and the P-3 unit (which has 30 ICF beds). When we visited the Q2 unit in particular, four staff members had to be kicked out of the room we used for confidential interviews with class members. In the A2 unit, which houses the Day Treatment Program and also has only one room for all clinical and other contacts, I was struck by the number of men housed in their cells in the middle of the day. When I asked Dr. Noorani, a psychiatrist in the unit, why so many men were in their cells in the middle of the day, he explained that they had to cancel a group so that I could use the one available room for interviews.

50. The treatment and office space limitations are also severe for the CDCR mental health programs at CMF. I spoke with a clinician who works in the M2 unit (an EOP unit), for [22] instance, who reported that there was no interview space available for staff and that the one available room must be shared with 4 or 5 other clinicians who frequently walk in and out of the room. In fact, the defendants recently submitted a plan to the *Coleman* court admitting significant treatment and office space shortages in the L, M, and N-wings for EOP patients and proposing to build 16 group therapy rooms, 28 interview rooms, 4 recreational therapy rooms, 6 education classrooms

and "appropriate support space for staff." Coleman Pls' Trial Ex. 59 at p. 4. CMF does not propose to start construction of these spaces until 2010, however, and does not anticipate completion until 2012 at the earliest. *Id.*

51. In my opinion, these space limitations are directly related to overcrowding. While the infrastructure of CMF is antiquated and inadequate, there is no question that there are simply too many people housed at the prison. The 20-person dorm spaces in units J1, J2 and J3, are a good example. Those units used to be dining rooms, but were converted to dorm housing spaces because of overcrowding. If the population were lower, spaces such as J1 could be used as programming areas, treatment spaces, or staff offices. The impact of these conditions on mental healthcare is significant—mental health assessments, case manager contacts and psychiatrist meetings are frequently done in non-confidential settings where other staff members and even other inmates may be around. Having one room available for all mental health contacts also necessarily means that groups and other contacts will be canceled when more intakes than usual are processed into a unit, when clinical sessions run overtime or when there are security or other incidents on the unit. My visit, in fact, resulted in the cancellation of at least one group at CMF.

The Use of Dorm Housing at CMF

52. Although CMF is one of the least overcrowded institutions in the system (133 percent of capacity based on population data as of August 6, 2008), it still has overcrowded dorm housing units. I toured the J1 unit, for instance, which has approximately 150 men split between 8, 12 and 20 person dorms.

Although I did not personally tour units J2 and J3, I was informed that they are identical to the J1 unit. Although the J1 unit has smaller dorms than places like the [23] gym dorms at MCSP, these units are difficult places for people with or without mental illness to live because they do not afford any personal privacy. These settings also may exacerbate mental health conditions such as paranoia and create stressful environments for people who are otherwise vulnerable due to mental health issues, including cognitive impairments.

53. Overall, CMF provides a good glimpse into systemic problems of accessing higher levels of care, medication management and crowded office and treatment space issues.

(c) *Mule Creek State Prison (MCSP) Tour*

MCSP Tour Overview

54. I toured Mule Creek State Prison (MCSP) on August 1, 2008. . . .

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[23] *Lack of Access to Higher Levels of Care, Including the Housing of Suicidal Inmates in MHOHUs and Administrative Segregation Units*

55. Because MCSP does not have ICF or acute beds, its biggest issue is providing adequate MHCB access to men who are suicidal or otherwise in crisis. During the morning meeting, both the Warden and the head registered nurse reported that the institution's MHCBs are almost always full and that while they are theoretically available to prisoners from other [24] institutions, they did not know of even one admission from an outside prison. Staff also reported that the overflow units to the MHCBs are also almost always full, including the cells set aside

as the Mental Health Outpatient Housing Unit (MHOHU) and five administrative segregation cells on C-yard.

56. The Chief Psychiatrist, Dr. Fowler, candidly talked about problems getting men into crisis beds and inpatient beds run by DMH. He said that it takes a lot of paperwork to do a DMH referral and significant staff time, which he estimated as 5-7 hours. I asked him if these problems resulted in fewer referrals to DMH and he said that they do. He said that staff sometimes opt to initiate the Keyhea process (to involuntarily medicate patients) rather than refer them to an inpatient bed. Dr. Fowler also told me that he prefers to keep some men at MCSP rather than refer them to DMH beds for "continuity" of care purposes. He admitted that this means he sometimes uses the MHCB unit to provide acute care. The data provided by MCSP shows that the institution admitted 42 patients into crisis beds during the three month period between April 1 and June 30, 2008. Five of the admitted patients stayed a combined 13 extra days due to administrative reasons, which were described as "medical quarantine, institutional emergency, cell unavailability due to overcrowding or custody unavailable to complete transport." Coleman Pls. Trial Ex. 141 at p. 2. When Dr. Fowler does not have open beds in the MHCB unit, he uses six cells designated as the MHOHU and then 5 administrative segregation cells if the MHOHU cells are full.

57. The Special Master has grave concerns about the systemic use of alternative placements due to shortages of mental health crisis beds. In his 20th monitoring report, he wrote:

> Fourteen institutions that did not have adequate access to licensed crisis beds resorted to using a variety of temporary monitoring arrangements, most of which were grossly inappropriate alternatives to acute care. Despite having 26 CTC beds and a 20-bed MHOHU, CSP/Sac referred inmates in holding cells for up to eight hours, held half of all MHOHU admissions for longer than 72 hours, and transferred 33 inmates to MHCB units in other prisons. MCSP used six MHOHU beds and five observation cells in administrative segregation to monitor inmates it was not able to admit to its eight-bed MHCB unit. CSP/LAC, KVSP, NKSP, SVSP, and WSP, all with licensed CTCs, routinely used holding cells and tanks to [25] monitor inmates for whom MHCBs were not available. CCI, CIM, and DVI used alternative sites to monitor inmates for whom OHU beds were unavailable. OHU admissions at ASP, CRC, CTF, SCC, and SQ routinely exceeded 72 hours because inmates were not timely referred and/or transferred to MHCB units.

Joint Pls' Trial Ex. 57 at p. 352-353. The Program Guide specifies that patients should not be housed in OHUs for longer than 72 hours except in limited circumstances. Joint Pls' Trial Ex. 9 at p. 12-5-28.

58. The Mental Health Outpatient Housing Unit ("MHOHU") at MCSP is a disturbing example of one of the overflow units to which the Special Master refers. The MHOHU is in a fenced-off area within an administrative segregation unit at MCSP. Staff reported during the morning meeting at MCSP that the MHOHU cells are usually full. Data provided during the tour showed that there were 125 patients admitted to the MHOHU between April 1st and June

30th of 2008, 33.6 percent of whom stayed in the MHOHU for longer than 72 hours. Coleman Pls' Trial Ex. 142 at p. 4. During my tour on August 1, 2008, four of the six cells were occupied by men who had been housed there, according to notes on their doors, for between one and eight days. The cells themselves are small, concrete rooms that are often completely bare aside from a small toilet and sink. In fact, two of the men I saw in these cells were wearing nothing but suicide smocks and had no mattress or blanket. They told me that they do not get a mattress or a blanket even during the night while they are sleeping, forcing them to sleep on the cold, concrete floor wearing only a suicide smock. The man who had been in the MHOHU for 8 days was lucky enough to have a one inch plastic-coated mattress, but reported that he slept on the bare concrete floor in a suicide smock and without a blanket for the first 7 days he was there.

59. The MHOHU cells at MCSP do not constitute anything even approaching an acute level of care. Attached to this report as *Appendix D* are pictures of a MHOHU cell that I saw during my tour. To the contrary, the conditions found in the MHOHU are likely to exacerbate many patients' clinical conditions and will ultimately dissuade people from communicating candidly with their doctors about their mental health conditions. My interviews [26] with two men who were currently in the MHCB unit, but who had spent time in the MHOHU support these opinions. One of those men (Class Member VVV) was wearing a suicide smock when I interviewed him and told me that he became so upset about being placed in the MHOHU without a mattress or a blanket that

he smeared feces in his cell.[3] The paperwork in his file confirmed this account. Class Member WWW, the other patient I interviewed in the MHCB unit, told me that he did not like the MHOHU, primarily because he was forced to sleep on a concrete floor without a blanket or a mattress. *See Appendix D.*

60. While it is essential that staff be vigilant about suicide precaution measures, which may include removing items like underwear, non-safety blankets and other clothing items, the conditions in the MHOHU are so extraordinarily harsh that they risk inhibiting people from coming forward about their mental health conditions. This, in turn, hampers mental health staff's ability to fully evaluate and treat their patients. It is my experience that word travels quickly among inmates about deplorable conditions they experience. This results in prisoners not reporting the extent of their suicidality out of fear of being housed in places like the MHOHU.

61. Yet the MHOHU placements are not the only overflow beds for the MHCB unit at MCSP. Mule Creek also sets aside 5 administrative segregation cells in the same cordoned off area where the MHOHU cells are located. They are therefore overflow to overflow cells in that they house people who have been referred for mental health crisis care but who cannot be housed in either a MHCB or a MHOHU bed. The Special Master found the following problems

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[3] When persons with mental illness smear feces, it is most likely due to acute, untreated psychosis. It can also be associated with people who are psychotic because of a serious mood disorder such as Bipolar Disorder, Manic and Schizoaffective Disorder, Manic. This behavior is also seen in individuals who have severe cognitive impairments such as mental retardation and dementia due to medical conditions.

with respect to the five administrative segregation cells: "The institution did not track the number or duration of placements in these cells. Inmates placed in the holding cells were reportedly monitored by custody staff on a one-to-one basis until they were either admitted to an MHCB or [27] returned to their cell in administrative segregation. Inmates placed in holding cells in administrative segregation reportedly received daily clinical contacts, most of which occurred cell-front. Contacts routinely occurred without the inmate's UHR, as the medical records for inmates retained in the observation cells were stored in the TTA of the CTC." Joint Pls' Trial Ex. 57 at p. 62.

62. Again, these overflow units are a direct result of overcrowding and represent the system's desperate and inadequate attempt to deal with a significant deficiency of inpatient beds. In fact, MCSP notified the Director of Mental Health for the Division of Correctional Health Care Services back in October of 2006 that 8 crisis beds were wholly inadequate for the October 2006 census of 265 EOP patients and that increasing the EOP population would seriously impede the provision of mental healthcare: "By doubling our EOP population without increasing acute care capacity the department would be taking an acute care program that is already too small for our current census and further overloading it . . . Failure to have adequate acute care capacity increases the risk of suicide and medical (mental health) negligence for our entire facility." Coleman Pls' Trial Ex. 143 at p. 1. Despite these warnings, MCSP's EOP population as of July 29, 2008 was 526 patients (261 patients *more* than MCSP had when it issued the memorandum to headquarters staff warning that eight MHCBs were wholly inadequate).

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[35] (a) *Systemic Problems with Seriously Delayed Access to Higher Levels of Care*

86. Perhaps the most disturbing and direct result of severe overcrowding is the terrible shortage of inpatient beds for *Coleman* class members. I am aware that the Special Master and the Receiver have been very concerned about this issue for some time. The Receiver documented the shortages in his 8th Quarterly Report, which was issued in June of 2008:

> At present, there exist serious shortages of mental health inpatient beds (including a waiting list of 162 for long-term intermediate care hospitalization). At present, CDCR simply does not have anything near adequate mental health treatment facilities for prisoners with serious mental health problems.

Joint Pls' Trial Ex. 56 at p. 48. The Receiver then discussed a recent death in a California prison that he attributed directly to this serious shortage of inpatient mental health beds:

> Patient B was a 36 year old male diagnosed with Hepatitis C antibody positive, paranoid schizophrenia, history of head trauma, borderline intellectual functioning, antisocial personality disorder, and history of substance abuse. Incarcerated continually since 1994, Patient B has been, in the past, admitted to both mental health crisis housing and administrative segregation housing. These placements were for safety concerns. Because of his mental health problem, Patient B was vulnerable to victimization when housed in "general population." He was last housed in general population, however, and also

> double-celled. On November 26, 2007, Patient B was found in his cell unresponsive with multiple wounds about the head, weak pulse, agonal breathing and fixed dilated pupils. He was transferred to a [36] local hospital, determined to be brain dead, and care subsequently withdrawn. According to CDCR officials, Patient B had been beaten to death by his cellmate.

Id. at p. 48.

87. The *Coleman* Special Master also documented serious problems with access to higher levels of care during his 19th and 20th round monitoring tours:

> Access to higher levels of mental health care at the DMH level remained slow. In addition, the ongoing need for sufficient MHCBs continued to challenge the institutional capacity to provide crisis care. Inmates' overly long stays in institutional OHUs and MHOHUs and their placements in holding areas reflect not only the continuing need for more MHCBs, but also the deferred access to inpatient levels of care needed by the more severely mentally inmates. For several years the defendants have been struggling with assessing their mental health bed needs, particularly at the most intensive levels of care, and developing a responsive long-term plan. Undoubtedly, the task has been challenging, for no less reason than the shifting nature of many conditions that affect CDCR and its mental health care. These challenges have included unprecedented growth in the prison population and resulting changes to population projections; understaffing of personnel at CDCR's own headquarters to execute the many parts of the planning task; and coordination with the California Prison Receivership, which has

> become engaged in the redesign of medical care, and to some extent mental health care, within CDCR institutions.

Joint Pls' Trial Ex. 69 at p. 131-132. In the draft 20th report, he noted, "Timely access to appropriate levels of care, essential to the efficacy of a mental health delivery service, continued to elude CDCR." Joint Pls' Trial Ex. 57 at p. 349.

88. The dire need for substantial additional inpatient, MHCB and EOP beds was apparent to me during my tours as I talked to and observed patients at every level of care. It was clear that the severe shortage of mental health beds has created a system that houses a significant portion of *Coleman* class members at lower levels of care than the patients clinically require. A significant number of class members who I interviewed at the EOP level of care, for instance, required inpatient psychiatric hospitalization. I base this statement on my clinical evaluation of those patients, on my review of their medical charts and on my knowledge of the MHSDS system during the time that I was monitoring the *Gates* consent decree. I also interviewed several patients in DMH intermediate care facility placements that, in my opinion, required acute [37] psychiatric hospitalization. I was struck by the very high acuity of the patients I encountered during my tours because they were much sicker, as a whole, than the *Coleman* class members I encountered between 1990 and 2000 while monitoring CMF as a medical and psychiatric expert for *Gates*.

MHCB and EOP Patients Who Require Inpatient Care

89. The following are examples of class members from my recent tours who I believe require a higher level of mental healthcare than was currently being provided:

a) I interviewed *Coleman* Class Member VVV in the MHCB unit at MCSP on August 1, 2008. He was designated at the EOP level of care. The medical file reflected that Class Member VVV is diagnosed with Schizophrenia or Schizoaffective Disorder. His "Inmate Profile" shows that he is also diagnosed with Dementia due to HIV disease or Cognitive Disorder NOS, although I did not see these diagnoses in his medical file. Coleman Pls' Trial Ex. 145. He was prescribed the following medications: Risperdal (37 1/2 mg. shot every 2 weeks); Lexapro (20 mg. daily dose) and Trazodone (unknown daily dose). The "Inmate Profile" sheet shows a significant suicide attempt history and also shows that while he was referred for acute inpatient care at DMH on February 20, 2008, he was not placed in an acute bed until June 6, 2008. The MHCB 2nd Quarter Chart shows that he was housed in an MHCB for 37 days between April 30 and June 6, 2008. Coleman Pls' Trial Ex. 141. Class Member VVV reported that he was in the MHOHU previously, where he smeared feces in his cell because staff would not provide him with a mattress or blanket. Pictures of a MHOHU cell are attached to this report as *Appendix D.* The "Patient Activity Report-Inhouse" log shows that he was admitted to the MHOHU three times between June 24 and July 22, 2008 (4/24-4/30; 7/4- [38] 7/7 and 7/22 for one day). Coleman Pls' Trial Ex. 146 at p. 13. In my opinion and based on Class Member VVV's clinical presentation and his significant suicide history, he exceeds the EOP level of care and should be housed in an inpatient setting.

b) I interviewed *Coleman* Class Member XXX at SVSP on July 29, 2008. Class Member XXX was floridly psychotic when I spoke with him, was also manic and was religiously preoccupied. His file reflected that he was not taking medications despite documented assaults on staff due to untreated mental health issues. He is also not listed on the Keyhea "active cases" log from SVSP dated July 20, 2008. Coleman Pls' Trial Ex. 147 at p. 4. Despite his condition, Class Member XXX was housed in an administrative segregation unit with active mental health issues that were not being treated. He is designated at an EOP level of care, but in my opinion, requires inpatient psychiatric care.

c) I interviewed *Coleman* Class Member YYY at SVSP on July 29, 2008. Class Member YYY was very paranoid, could not maintain eye contact, and was responding to internal stimuli. He also had significant cognitive impairment. The "inmate history" sheet provided by the institution shows that he has a diagnosis of Schizoaffective Disorder and is at the EOP level of care. He was prescribed Zyprexa (daily dose of 10mg) and Cymbalta (daily dose of 60 mg). Although Class Member

YYY was being housed at the EOP level of care, I believe he requires inpatient care based on his clinical presentation and his active psychosis. Clinicians at the institution agree that Class Member YYY needs an inpatient level of care as he has been waiting for an inpatient bed since his 11/8/07 referral (or for nearly 9 [39] months as of the date I saw him). Coleman Pls' Trial Ex. 118, Patient 622.

d) I interviewed *Coleman* Class Member ZZZ at SVSP on July 29, 2008. Class Member ZZZ reported, and his file confirmed, that he made a serious suicide attempt more than a year before and had been waiting for an intermediate care facility bed ever since that time. The "Inmate History" sheet provided by the institution shows that he has a diagnosis of Bipolar I disorder, severe with psychotic features. Coleman Pls' Trial Ex. 148 at p. 1. He was psychotic and labile when we spoke and had low frustration tolerance. He was also on very high doses of medications as follows: Buspar (60 mg. daily dose); Zyprexa (30 mg. daily dose); Inderal (60 mg. daily dose); Visteril (150 mg. daily dose), and; Lithium (900 mg. daily dose). While CDCR clinicians agreed that Class Member ZZZ needs inpatient care, he has been housed at the EOP level for nearly a year awaiting that placement. The SVPP waiting list reflects that he has been waiting for an inpatient bed since his September 6, 2007 referral (or nearly a year as of the date I saw him). Coleman Pls' Trial Ex. 118, Patient 607.

e) I interviewed Class Member LL at SVSP on July 29, 2008. Class Member LL was floridly psychotic during our interview and had strange ideas of reference. He believed that the FBI was sending lasers into his cell through wires and he also believed that his wife worked on the *Coleman* lawsuit in San Francisco. He had been admitted for mental health crisis care five times in 2007 and once already in 2008 according to his "Inmate History" printout. Coleman Pls' Trial Ex. 149 at p. 28. His file reflected that he was on Keyhea and that he was currently taking the following [40] medications: Risperdal Consta (37 1/2 mg. every 2 weeks) and Risperdal (2 mg. daily dose). He was diagnosed with Schizoaffective Disorder. It appears from a DMH log that clinicians referred Class Member LL to an ICF bed on September 27, 2007 and that he was "accepted" for the bed on January 22, 2008. He then sat on the waiting list until May 4, 2008, when someone rescinded his referral. Class Member LL needs a higher level of care than EOP as evidenced by his clinical presentation and his multiple mental health crisis bed placements since 2007. Coleman Pls' Trial Ex. 117, Patient 570. In my opinion, he should not have been removed from the ICF waitlist.

f) I interviewed Class Member AAAA at SVSP on July 29, 2008. Class Member AAAA was being treated at the EOP level of care and was diagnosed with Schizophrenia. According to his file and my conversation with him, Class Member AAAA had a significant violent history, which included decapitating his father with a machete. His "Inmate History" shows that he was on Keyhea since November 2, 2007 (order expires November 1, 2008). Coleman Pls' Trial Ex. 150 at p. 38. He was also on a very significant amount of medications, including the following: Haldol Decanoate (100 mg. shot every two weeks); Cogentin (2 mg. daily dose); Zyprexa (20 mg. daily dose). Despite being prescribed a significant amount of medication, including four times the normal dose of Haldol Decanoate, Class Member AAAA was still very ill and requires inpatient care. In my opinion, he should have been promptly transferred to an inpatient psychiatric hospital. According to the DMH referral log, clinicians referred Class Member AAAA to an inpatient bed on February 20, 2008, but he was sent back to the EOP unit to wait for that bed. [41] Coleman Pls' Trial Ex. 151 at pp. 1-2. It also appears that staff lost his referral package at one point, which required SVSP to send a replacement. His Inmate History also shows that Class Member AAAA saw seven different psychiatrists for psychotropic medications between June of 2007 and June of 2008.

g) I interviewed Class Member BBBB at CMF on July 30, 2008. Although Class Member BBBB was in an intermediate care facility placement when I interviewed him, there was a July 29, 2008 physician note discharging him back to the EOP level of care. Class Member BBBB was diagnosed with Schizophrenia, Paranoid Type, Depressive Disorder, NOS, and Polysubstance Dependence and was prescribed the following medications: Abilify

(30 mg. daily dose), and; Remeron (30 mg. daily dose). I saw paperwork for two different people in Class Member BBBB's file and when I asked him about it, he said that he was both men. I told him that the men were born five years apart based on the paperwork and he confirmed again that he is both men. In my opinion, Class Member BBBB was not appropriate for discharge to an EOP level of care and requires inpatient mental health treatment. Unless Class Member BBBB has an alias, it also appears that his medical file may contain documents about a different *Coleman* class member.

h) I interviewed Class Member CCCC at MCSP on August 1, 2008. Class Member CCCC was housed in administrative segregation at the EOP level of care and appeared to have been there for a very long time. His file showed that he was diagnosed with "Psychosis NOS," but his "Inmate History" lists his diagnosis as Schizophrenia, Paranoid Type. Coleman [42] Pls' Trial Ex. 152 at p. 1. His file showed that he was diabetic and that he was being treated for his mental health issues, as of July 25, 2008, with a 20 mg. daily dose of Abilify. His "Inmate History," however, which is dated August 1, 2008, shows that all medications were stopped on January 27, 2008. He reported that he was previously housed in inpatient beds at both CMF and SVSP. At the time of our interview, Class Member CCCC was floridly psychotic and was responding to multiple internal stimuli. The "Patient Activity Summary" shows that he had three admissions to the MHOHU between April 19 and June

25, 2008 for a total of 27 days in the MHOHU. Coleman Pls' Trial Ex. 146 at p. 15. Based on the information in Class Member CCCC's file and his clinical presentation, he very clearly needs inpatient care and is not appropriately housed at the EOP level of care.

i) I interviewed Class Member FFFF at CMF on July 30, 2008. His case manager progress note, dated 7/25/08 shows that he has a diagnosis of Schizophrenia, Paranoid Type, and Polysubstance Dependence. Coleman Pls' Trial Ex. 153 at p. 1. His file showed that he was prescribed Risperdal Consta (50 mg. every 2 weeks); Risperdal (4 mg. daily dose) and Thorazine (200 mg. daily dose). His "Case Manager Progress Note" shows that he is on a Keyhea as a "DTO" (Danger to Others). According to the medical file, staff referred Class Member FFFF to an intermediate care placement on January 28, 2008, but he was waiting at the EOP level of care until a bed opened up for him. I agree that Class Member FFFF requires inpatient care. Because there are no beds, however, he has been forced to stay in a clinically inappropriate placement for nearly six months. The severity of his mental illness is demonstrated by numerous [43] assaults on staff and other prisoners, his history of inpatient admissions and his suicidal history.

Intermediate Care Facility Patients Who Require Acute Care

a) I interviewed Class Member DDDD at SVSP on July 29, 2008. Class Member DDDD was very psychotic and displayed prominent negative symptoms. He was paranoid and had a history of staff assaults. He was also prescribed significant medications, including two antipsychotics and one mood stabilizer as follows: Risperdal (8 mg. daily dose); Seroquel (400 mg. daily dose), and; Depakote (1000 mg. daily dose). In my opinion, Class Member DDDD was inappropriate for ICF care due to his excessive psychosis and paranoia and his history of staff assaults. He requires placement in a locked hospital setting that provides acute care.

b) I interviewed Class Member EEEE at CMF on July 20, 2008. He had been housed in an intermediate care facility bed since December 3, 2007 and had a significant violent history. Class member EEEE was diagnosed with Schizoaffective Disorder (depressive type) with Polysubstance Dependence in remission. His October 24, 2007 "Mental Health Treatment Plan," however, listed his diagnosis as Schizophrenia, Paranoid Type, and Polysubstance Dependence in remission. Coleman Pls' Trial Ex. 154 at p. 3. He was prescribed the following medications: Depakote (1750 mg. daily dose); Prozac (40 mg. daily dose); Propranalol (20 mg. daily dose); Zyprexa (25 mg. daily dose), and; Benadryl (100 mg. daily dose). Class Member EEEE is in my opinion too sick to be at an intermediate level of care and requires placement in an acute hospital setting. He continued to display extensive thought blocking by competing [44] stimuli despite being housed at the ICF level of care for more than seven months and despite being prescribed large doses of anti-psychotic and mood stabilizing medications.

90. These class members (and the two men I saw in the acute unit at CMF) were some of the most acutely ill people I have seen. When I said this to Dr. Gandhi, the Director of DMH units at CMF, she agreed that the acuity level of her patients is quite high and, as mentioned in the next section, attributed the high acuity in large part to medication problems.

91. The reality of the current MHSDS system, as demonstrated by my interviews with these class members and the admitted shortage of EOP, MHCB and inpatient beds, is that too many people are housed in places that simply cannot provide them with the level of mental health care they require. This is a direct result of overcrowding—there are too many people in the system and too few resources to treat them. This in turn means that the acuity at every level of care is higher than it would be in a system that has sufficient inpatient beds. I saw this time and again during my tours—there were inadequate mental health crisis beds for people experiencing acute mental health episodes, which meant that many of those people are housed in inappropriate "overflow" placements such as MHOHUs or administrative segregation units. The significant 171 patient waitlist for intermediate care facility beds also means that patients who need inpatient care are instead waiting in EOP units, in valuable MHCBs or in the various "overflow" units. Once those people are admitted to inpatient beds, sometimes after many months of living in clinically inadequate placements, they are sicker and more acute than they would have been had they been promptly provided adequate care. As Dr. Gandhi, the Director of DMH

units at CMF expressed, this means that the inpatient units as a whole are admitting extremely acutely ill patients. The waitlists for acute beds and mental health crisis beds only add to this crisis.

92. There are serious clinical and systemic consequences of having too few beds at nearly every level of care. First are the individual consequences for patients. By not providing [45] adequate and timely care, people are decompensating and are ending up in mental health conditions far more acute than necessary. This translates into longer stays in inpatient beds and the consumption of greater resources for longer periods of time than the person might otherwise have required. Second are the systemic consequences of these backlogs. It is taking longer to stabilize and treat the people coming into inpatient mental health beds, which means that those people consume valuable resources for longer periods of time. In other words, the lack of sufficient inpatient beds creates a cycle of sicker people being admitted, with greater resources necessary to treat them, which then creates even further backlog in an already overwhelmed system.

(b) *Systemic Problems with the CDCR's Medication Management System*

* * * *

[49] 100. These medication management problems are typical in overcrowded systems. The consequences are just as Dr. Gandhi described—patients are coming into DMH units with very acute mental health problems, are taking longer to stabilize on medications and are then returned to the same system that fails to adequately monitor medication compliance, thereby starting the cycle all over again.

A disturbing suicide that happened in the C-12 administrative segregation building at MCSP on January 22, 2008 illustrates this dangerous cycle, as well as the consequences of having too few crisis placements. Class Member GGG had a history of inpatient placements due to the severity of his underlying psychotic process, and a history of suicidal ideation and medication non-compliance. Coleman Pls' Trial Ex. 144 at p. 3-5. On September 19, 2007, he was admitted into an acute bed at CMF, where staff were able to stabilize him and get him to take his medications. *Id.* at p. 5. He was discharged to the EOP level of care and arrived at MCSP on 11/2/07 with a recommendation that he continue to take his medications. *Id.* at pp. 5-6. Although a psychiatrist at MCSP continued the prescription initially, he discontinued the medication on 11/13/07. *Id.* at p. 6. Class Member GGG then apparently decompensated over a period of two months. There were no progress notes in his medical file from a psychiatrist between November 13, 2007 (the day he was removed from medications) and January 22, 2008, the day he killed himself. *Id.* at p. 7. Meanwhile, his case manager realized that he was decompensating, particularly after receiving news that he received four additional years added to his sentence for pushing a food tray out of his cell back in June of 2007, which apparently hit a correctional officer. *Id.* at p. 6. On January 10, 2008, the case manager talked to the psychiatrist about initiating Keyhea, but apparently did not do so. *Id.* at p. 7. She noted the same plan on January 17th but an order still was not initiated. On January 22nd, the case manager saw Class Member GGG for a crisis evaluation after he pushed his cell door into correctional officers when they were trying to close it. *Id.* at

p. 7. Staff planned to admit him into the crisis unit at that point and initiate the Keyhea process. *Id.* After learning that the [50] restraint room was not available and that there were no crisis beds open, staff moved Class Member GGG back to his administrative segregation cell without any prescribed observation. *Id.* at p. 11. He hanged himself that night in his cell. This suicide is a disturbing example of an institution's failure to maintain the clinical gains achieved at a higher level of care, its failure to appropriately monitor and prescribe necessary psychotropic medications and its failure (in this case fatal) to provide a mental health crisis bed to an acutely ill patient.

* * * *

[52] (e) *The Impact of Overcrowding on Suicide Rates*

107. I discussed the impact overcrowding has on suicide rates in my prior report. 11/9/07 Report at pp. 75-81. In particular, I noted that the suicide rate in the CDCR has significantly exceeded the national average of 14 per 100,000 during both 2005 (21.9 per 100,000) and 2006 (at least 25 per 100,000 prisoners). *Id.* at p. 76. The CDCR had at least 43 suicides in 2006, reported 35 confirmed suicides in 2007, and, according to plaintiffs' counsel, has reported 24 suicides this year as of August 15, 2008. The Special Master's draft report about 2006 suicides found that 72 percent of the completed suicides in 2006 "involved some measure of inadequate treatment or intervention and were, therefore, most probably foreseeable and/or preventable." Joint Pls' Trial Ex. 58 at p. 8.

108. My prior report explained:

> [O]vercrowding increases both the prevalence and the severity of mental illness. Put another way, overcrowding both creates new mental illness and makes existing mental illness worse. Since many or most suicides are due to the presence of severe mental illness or the onset of a severe mental health crisis, it is clinically reasonable to anticipate a higher suicide rate in an overcrowded system. Another way to think about the correlation between overcrowding and suicide rates is to see overcrowding as a broad environmental factor increasing the risk of suicides by creating a larger class of at-risk individuals.

11/9/07 Report at p. 76.

[53] 109. The Special Master's finding that more than 70 percent of the 2006 suicides were preventable is extremely disturbing. In my opinion, much of the suicide risk in the CDCR is related to overcrowding. One recent suicide in particular illustrates the consequences of an overburdened system. Class Member HHH hanged himself in an unlicensed infirmary at Correctional Training Facility (CTF) on March 18, 2008 and died two days later when he was removed from life support. A few days prior to his admission into the infirmary, a staff member found Class Member HHH unresponsive in his administrative segregation cell due to a suspected drug overdose; he also had dried blood on his wrist. He was transported to an outside hospital and then returned to the infirmary. A March 16, 2008, clinical note shows that staff recommended placement in a mental health crisis bed, but did not pursue that placement. A psychiatrist interviewed him on March 17, 2008 and noted that he was a "high suicide risk," but then reduced the observation to one hour rounding rather

than the 15-minute watches. The next day, Class Member HHH hanged himself with a noose that he made out of torn towel pieces. Coleman Pls' Trial Ex. 155. The report also reflects that staff were confused about the correct suicide precaution and watch standards that should have been followed.

110. This suicide illustrates several aspects of the CDCR's overburdened system, including the danger of placing prisoners in alternative placements, the delayed access to higher levels of care (which in this case seems to have never been pursued), confusion among staff about suicide watch and observations procedures, and failure on the part of the attending psychiatrist to order clinically appropriate suicide precautions.

4. Overcrowding is the Primary Cause of the Constitutional Violations in the CDCR

111. These overcrowding-induced conditions that currently exist in the CDCR are extremely detrimental to the *Plata* and *Coleman* class members. The conclusion that overcrowding is the primary cause of these violations is inescapable for several reasons. I also stated these reasons in my November 9, 2007 Expert Report and have updated the following sections only as appropriate based on updated information.

[54] (a) *The Persistence of the Constitutional Violations Present in the CDCR Demonstrates that They Are Caused by Overcrowding*

112. First, taken together, the range of Constitutional violations discussed above, including inadequate suicide monitoring and prevention, inability to timely access appropriate levels of care, inability to timely access mental health clinicians due to staffing shortages, and inadequate medication management

practices are unusual in a system that has been under Court supervision for more than ten years. These serious, dangerous violations this late in the remedial process are typical indicators of a system plagued by severe overcrowding. In a non-overcrowded system, the Constitutional violations are more readily addressed by such interventions as increased staff and increased programming. However, in a system overwhelmed by crowding, these traditional remedies are woefully inadequate. This appears to be the case in the CDCR where remedial efforts have resulted in significant expansions of staffing and programming activities, yet the constitutional violations persist or even worsen.

(b) *The Coleman Special Master Has Found That Overcrowding Has Undermined Progress That Was Being Made In Various Areas*

113. The *Coleman* Special Master has observed that, although there was a period of time when it seemed that defendants might be making progress in terms of their bed plan and the provision of treatment, the overcrowding crisis has overwhelmed this hope. In his April 12, 2007 Report to the Court, he concluded: "By late 2005, it was evident that the reduction in population growth and then in the population itself in the first few years of the decade were over, and the numbers were rising fast. Early in 2006, defendants were staring at a galloping growth rate that threatened to hit 200 percent of capacity shortly, and the scramble was on to deal with the flow. One victim of the turnaround was CDCR's mental health bed plan." *See* 4/12/07 Special Master's Report on Defendants' Establishment of Interim Inpatient Intermediate DMH Beds at 8.

[55] (c) *The Percentage of Caseload Inmates in the CDCR is Increasing Faster than the Overall Population*

114. Another factor that demonstrates that overcrowding is the primary cause of the constitutional violations is the fact that the percentage of persons with serious mental illness in the CDCR is increasing faster than the overall CDCR population. Between January of 2003 and July of 2007, the population of the CDCR's prisons and camps grew from 152,396 to 165,932, an increase of 8.9 percent. *Coleman* Pls' Trial Ex. 34 and 35 (Monthly population figures downloaded from the CDCR website for January 2003 and July 2007). During the same period, the MHSDS caseload of EOP and CCCMS inmates grew from 24,599 to 32,039, an increase of 30.2 percent. *Coleman* Pls' Trial Ex. 36 (CDCR MHSDS Prevalence Data for January 2003 and July 2007 from CDCR Monthly Reports). Thus, during this period of roughly four and one-half years, the mental health caseload grew at four times the rate of increase for the overall population.

115. Since my last report, the overall CDCR population has decreased while the MHSDS population continues to increase. From July 2007 to June 2008, the overall population went from 165,932 to 160,169, a *decrease* of 5,763 inmates. Coleman Pls' Trial Ex. 35 and Joint Pls' Trial Ex. 103. At the same time, the MHSDS has increased from 32,039 to 34,035, or by 6.2 percent.

116. This is typical of overcrowded systems because, as I have stated previously, overcrowding creates new mental health needs and exacerbates existing mental health needs. I encountered numerous examples of this on my various prison tours in preparing this

opinion. As the data supports, the net result of overcrowding is a greater incidence of mental illness and at a more acute level. Traditional remedial efforts such as increased staffing will be insufficient to remedy this problem and, in a system like the CDCR's where office and treatment space is severely limited, might actually create additional overcrowding problems. Finally, as stated previously, overcrowding expands demand at the highest levels of care and creates static backlogs of patients that make it difficult to assess the true demand for services.

[56] (d) *In Many Instances, the Overcrowded Conditions Themselves Are the Cause of the Unconstitutional Mental Health Care*

117. The causal link between overcrowding and unconstitutional mental health care is clear and direct in the many CDCR housing units where space shortages from overcrowding directly result in long-term living arrangements that are harmful to the mental health of *Coleman* class members. For example, CCCMS inmates are routinely double or even triple-bunked in chaotic, overcrowded dorms where they experience damaging levels of stress and fear of predation. It is clear that the mentally ill inmates I interviewed at Solano who also had staph infections would not have been as ill if they were not living in overcrowded conditions. Similarly, mentally ill inmates are retained for extended periods in Reception Centers and in locked down general population units, where they are locked in their cells for most of the day and receive little or no programming or mental health services. Such environments add to the instability of persons with mental illness. Another context in which the link is clear is improper place-

ments in administrative segregation, where caseload inmates are often unable to access care and experience decompensation. Yet another context is suicide watches in holding cells, cages, tanks, administrative segregation units, and other unsafe, unlicensed, and improperly supervised environments. These same harsh conditions, as discussed earlier, also increase the demand for mental health services in prisoners in the general population who, in a properly operating, not overcrowded system, would not need mental health services. Isolation, seclusion, idleness, violence, fear and stress plague the prisoners in the CDCR as a direct result of overcrowding. These conditions exacerbate mental illness and are serious barriers to the provision of minimally adequate mental health and medical care.

B. *Opinion 2*: Other Remedial Efforts, Other than Population Reductions, Will Not Succeed In Remedying The Underlying Constitutional Violations.

1. Defendants' Current Plans to Fix the System Will Not Work

118. In my opinion, no other relief will remedy the underlying constitutional violations except a remedy which results in a substantial reduction in the prison population. I also stated [57] this opinion in my November 9, 2007 Expert Report and have updated the following sections only as appropriate based on updated information.

119. I am aware that the *Coleman* court has issued at least seventy-seven orders intended to induce the State to provide constitution levels of mental health treatment in the CDCR. The *Coleman* court concluded in its July 23, 2007 Order referring consideration of a

prisoner release order to the three-judge panel: "Since February of 1996, this court has issued at least seventy-seven substantive orders to defendants in an effort to bring the CDCR's mental health care delivery system into compliance with the requirements of the Eighth Amendment. Taken together, these orders have contained directives aimed at all of the aforementioned requirements for a constitutionally adequate mental health care delivery system. In addition, the Special Master and his staff have spent hundreds of thousands of hours working with the parties to develop program guidelines for a constitutionally adequate system and monitoring defendants' implementation of those guidelines. During the same period of time, the Special Master has filed seventeen semi-annual monitoring reports and fifty-five other reports reflecting the results of these efforts." 7/23/07 Order at 4:13-21. More orders and reports have issued since last summer.

120. Having worked as a correctional expert and having worked on the *Gates* and *Madrid* cases, I am very familiar with the monitoring team working for the court on the *Coleman* case. Moreover, having reviewed the recent monitoring reports and the other documents in this case, it is clear that very intensive remedial monitoring efforts have been going on in the *Coleman* case for many years. In my opinion, the large team of national experts working as court-appointed experts in the *Coleman* case has a great deal of collective experience working with troubled correctional systems. Nonetheless, after more than ten years of intensive monitoring and other remedial efforts, the CDCR remains plagued by serious constitutional deficiencies in its delivery of mental health care. I agree with the *Coleman* Special Master that the reason for this sorry state of affairs is that

whatever tentative progress was made early on in this case has been overwhelmed by the massive population expansion in recent years.

[58] 121. From reviewing the docket in the *Coleman* case, I am aware that these more than seventy-seven orders have attempted to address issues of staffing, space, quality of treatment, and bed availability, among others. These include numerous orders concerning such critical issues as adequate MHCB capacity (see, e.g., 1/15/01, 12/20/01, 10/8/02 Orders); access to DMH beds (see, e.g., 5/22/98, 7/26/99, 8/28/00, 4/4/01, 6/27/01, 3/4/02, 5/7/02, 10/8/02, 1/19/04, 7/9/04, 6/30/07, 8/8/08 Orders); and staffing (see, e.g., 2/17/96, 6/17/98, 8/25/99, 1/19/99, 7/26/99, 1/13/00, 4/27/00, 8/28/00, 6/13/02, 10/8/02, 3/3/06 Orders).

122. Persistent shortages of beds at every level, lack of adequate mental health and custodial staff, and inadequate treatment and programming space clearly reflect the overcrowding crisis. In my opinion, more orders by the Court along the lines of those discussed above will not remedy the underlying Constitution violations at this time. The system is simply too overwhelmed by the population for these orders to be effective.

123. I am also aware that the State has proposed construction of new prisons and re-entry facilities as the bulk of its solution to the overcrowding crisis. I have reviewed the Receiver's analysis in his Reports regarding overcrowding and the further demands for mental health and medical staffing, and treatment space that building these new prisons and re-entry facilities will create. As the Receiver notes, building more prisons and re-entry facilities will require additional staff, and will spread existing overtaxed staff among more facilities. *See* Joint Pls' Trial Ex. 26

(Receiver's 5/15/07 Report Re Overcrowding) at 40-41. The building timeline for the beds contemplated by AB 900 does not anticipate any new beds until 2009, and most of the beds will be built much later. *See Coleman* Pls' Trial Ex. 40 (January 2007 CDCR Estimated Construction Schedule for Infill Bed Plan, Ex. 20 to Receiver's 5/15/07 Report). Moreover, as the delays associated with the CDCR's plans to construct walk-alone yards demonstrate, construction projects involving government agencies are rarely finished by the anticipated dates. In my opinion, any added capacity for mental health and medical treatment that this prison construction may create will take far too long to be sufficient to remedy the current constitutional violations, which are extremely urgent and life threatening. This plan also fails to address the [59] other persistent, intractable overcrowding-related problems that are present in the CDCR, such as clinical and custody shortages, inadequate medication management practices, and insufficient beds at the highest levels of care.

124. Similarly, defendants' and the Receiver's plan to meet the needs of *Coleman* and *Plata* class members by building "Consolidated Healthcare Facilities" (CHCFs) is a long-term goal that is insufficient to address current Constitutional violations. According to defendants' July 16, 2008 mental health bed plan, "[c]onstruction sites and schedules for the CHCFs are still in development, with anticipation of *the first 1500-bed facility targeted to begin construction* in January 2009, anticipating completion by January 2011. There are eight sites being considered; land availability, infrastructure capability, environmental concerns, and political climate, among others, drive the ability to select, schedule and begin construction." Coleman Pls' Trial Ex. 55 at p. 4. It is also apparent

from the Receiver's 8th Report that the entire project to build CHCFs is in jeopardy. He discusses the need for 10,000 medical and mental health beds ("no one seriously disagrees with these projections") and explains that, "the scope of the existing shortfall in treatment facilities provides yet another example of the seriousness of the State's long-term failure to provide constitutionally adequate medical and mental health facilities for its prisoners." Joint Pls' Trial Ex. 56 at p. 46. Despite the dire shortage of approximately 5,000 mental health beds and 5,000 medical beds, the State has thus far ignored the Receiver's efforts to get the CHCFs funded. As he explains:

> The State's failure to make this necessary financial commitment puts the Receiver's entire remedial program at risk since the various pieces of the program are so intertwined and interconnected that failure to fund and implement one major element undermines all of the other elements. Unfortunately, the State's failure to make the necessary financial commitment is not a result of inadvertent neglect or mere incompetence (trained or otherwise). Instead, it is a result of conscious, deliberate obstruction by key decision-makers and decision-influencers resulting in a willful failure by the State to live up to its constitutional and court-ordered obligations. This is not a charge that the Receiver makes lightly; he has spent the last fifteen years working within State government processes to improve government operations. The State has now crossed that line and, in so doing, demonstrates a lack of remorse and an unwillingness to accept accountability for [60] its own constitutional violations. The State's failure to express its unequivocal commitment to the

> Receiver's necessary construction program should be taken into account by this Court in subsequent proceedings, and by the *Coleman*, *Armstrong* and *Perez* Courts.

Id. at p. 56.

125. Even if the Receiver's construction plan had funding, however, the Receiver anticipates building only one of the five hospitals by 2011 in the best case scenario. The fact that the plan is currently unfunded means that the 2011 and all other deadlines are in jeopardy. It is also significant that the Receiver's plan does not address all of the required shortfall of EOP, MHCB and ICF beds. The CDCR, which has a very poor track record of completing construction projects on time, is still tasked with a series of construction projects, including, for example: the 64-bed ICF unit at SVSP; the 64-bed ICF unit at CMF; the 50 bed MHCB unit at CMC; the 32 MHCB unit at San Quentin and; the 67 EOP unit at CMF. Coleman Pls' Trial Ex. 55 at p. 7. Meanwhile, the *Coleman* and *Plata* class members are daily suffering dangerous denials of mental health care and medical care that place them, their fellow inmates, the officers who supervise them, and the public at risk. The only way to timely correct the endemic denials of appropriate mental health care that currently exist in the CDCR is to significantly reduce the population. No other remedy will result in a constitutional medical and mental health care system in the CDCR.

2. The State Must Make Substantial Reductions in the Prisoner Population

126. I conclude that the prison population must be substantially reduced in order to provide adequate mental health care in a timely manner to the

prisoners with mental illness who are suffering every day in the California prisons. In 2004, the Corrections Independent Review Panel appointed by Governor Schwarzenegger worked with experienced wardens to determine the "Maximum Operable Capacity" (MOC) of the prisons system. The Panel defined MOC as "the percentage of design capacity of the various housing units within the institutions wherein the prison can be operated both safely and can provide programming for every inmate, consistent [61] with the inmate's ability." Joint Pls' Trial Ex. 4 at p. 161. The MOC incorporated educational, vocational, substance abuse, and other rehabilitation programming, but did not account for programming associated with mental health or medical treatment. Coleman Pls' Trial Ex. 108 at p. 113:15-17. The Panel concluded that the MOC for male prisons statewide was 145 percent of design capacity.[7] Joint Pls' Trial Ex. 4 at p. 124. The MOC made two assumptions: first, all "bad beds" would be closed so that program space would be available, and second, there would be sufficient "staff with requisite experience" available to manage an effective program. *Id.* at p. 161.

127. When mental health treatment needs are taken into account, the maximum operable capacity will be lower. The *Coleman* Special Master reported to the Court on May 31, 2007 that "[g]iven the inadequacies of programming space, program beds and mental health staffing . . . defendants cannot meet at least a substantial portion, amounting in some loose

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[7] Design capacity was determined to be 76,879 inmates at that time. Joint Pls' Trial Ex. 4 at p. 123. On January 25, 2007, the Little Hoover Commission issued a report updating the design capacity to 83,219. Joint Pls' Trial Ex. 3 at p. 19.

amalgam to about 33 percent, of acknowledged mental health needs . . ." Joint Pls' Trial Ex. 35 at pp. 12-14.

128. The operable capacity estimation by the California wardens also probably reflects a degree of institutionalized acceptance of overcrowding on the part of the wardens themselves that may have driven them to overestimate capacity. The *Plata* Receiver has documented "CDCR's institutionalized acceptance of overcrowding and the lowering of correctional standards to accommodate overcrowding." Joint Pls' Trial Ex. 26 at p. 10. The Receiver found that decades of prison overcrowding in California resulted in the parallel evolution of "a correctional mindset that allows *overcrowding* rather than *sound correctional management* to drive crucial construction and prisoner management policy." *Id.* (emphasis in original). Moreover, the Receiver found that the CDCR Facility Master Plans spanning 1993-2003 similarly failed to account for medical, mental health, and dental care programming needs. [62] Indeed, CDCR knowingly planned construction of even its newest prisons to provide at most fifty percent of all health care related space needs, "ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity." *Id.* at p. 20. These facts suggest that the Maximum Operable Capacity is actually lower than the Corrections Independent Review Panel's conclusion of 145 percent.

129. At a minimum, it is clear that the prison population must be reduced to a level, whether 145 percent or lower, that allows the State to meet the assumptions that the Corrections Independent Review Panel laid out for maximum operable capacity. All bad beds must be eliminated, sufficient program space must be identified and made available, and the number of inmates must correlate with available

appropriate clinician and custody staffing, in terms of both numbers and quality, to provide programming. It is not clear that the "serious staffing shortfalls" in CDCR prisons can accommodate 145 percent capacity (much less the near-double capacity they now face). Joint Pls' Trial Ex. 26 at p. 11 ("[O]vercrowding is accompanied by serious staffing shortfalls for both clinical providers and correctional officers.").

130. A maximum operable capacity that provides for the constitutional delivery of mental health care must expand the assumptions of the Panel to reflect the mental health treatment standards established by the *Coleman* Court. All "bad" mental health beds must be eliminated—for example, this means reducing the population to eliminate the use of alternative crisis beds, EOP "overflow" housing that does not have appropriate space for individual or group mental health contacts, and DMH units such as those currently run in SVSP D-5 and D-6, which are not set up to provide care consistent with inpatient standards. Adequate mental health programming space must be afforded. The operable capacity must also be related to the number of mental health and custody staff in the prison system providing mental health care, and the ability to provide these staff with adequate office and treatment space.

* * *

[70] IV. CONCLUSION

146. The extreme overcrowding in California's prison system permeates nearly every aspect of medical and mental health care and, if not remediated, will continue to result in preventable suffering and death. Unless and until the state reduces the population, it will be unable to sustain meaningful reform.

Dated: August 15, 2008

/s/ PABLO STEWART
PABLO STEWART, MD

EXHIBIT 8

Deposition of Robin Dezember
December 14, 2007
(Designations)

* * * *

[106] * * * *

MS. RIFKIN: The first page is the cover page, the second page is the exhibit page, and the third page is the cover page of the Corrections Independent Review Panel report from 2004.

MS. FRITZ: Got it.

MS. RIFKIN: What this is is specifically Chapter 7 from that report.

THE WITNESS: I was going to say, how did you get it so small.

Q. BY MS. RIFKIN: It's titled "Inmate/Parolee Population Management." Does this look like the report to you?

A. Yes.

Q. And you've seen this before?

[107] A. Yes.

Q. And this is Chapter 7 from the report for which you were a principal consultant?

A. As far as I can tell. I haven't read this whole thing. I'm assuming you put it in in an honest fashion, yeah. It starts at page 121, according to the table of contents. Do you want to look at it?

MS. FRITZ: Yeah. Just real quick.

Q. BY MS. RIFKIN: If you turn to the second to the last page of this exhibit, I hope it's a table.

MS. FRITZ: Is it Table 1?

MS. RIFKIN: Yes.

Q. Table I. Have you seen this table before?'

A. Well, probably. It isn't like it's familiar to me as of a week ago. But I know that I read everything in the CIRP report.

Q. Do you remember the report talking about different definitions of capacity?

A. Yes.

Q. And were you involved at all with this—with this chapter of the report?

A. Yes.

MS. FRITZ: Vague. Ambiguous.

THE WITNESS: I was involved, yeah. I was involved with this chapter.

[108] Q. BY MS. RIFKIN: What was your involvement specifically?

A. Well, I reviewed the chapter and there is—this I think is the chapter that talks about the—where we brought together a group of wardens and talked about capacity issues relative to their ability to operate safe and reasonable prisons. If that's in this chapter, that was my primary involvement in the generation of this chapter. And otherwise I was a reviewer of this.

Q. Okay. On the last page, that's page 161 of the exhibit, there are the notes for the table we just looked at. And note three defines maximum operable capacity.

A. Right.

Q. It says it was "determined through an assessment of experienced wardens." Is that the analysis that you just said that you were involved with?

A. Yes.

Q. Okay. Were you—was there—were wardens brought together for a meeting or were they—were they communicated with via conference call? How did that happen?

A. They were brought together for a meeting.

Q. And were you at that meeting?

[109] A. Yes.

Q. Do you remember that meeting?

A. Yeah, mostly. I can't be—not the details, I'm sure. But for the most part.

Q. What did they—what did the wardens base their assessment of capacity on?

A. You mean getting to this definition?

Q. Yes.

A. Their experience. It's really about all you can do with that.

Q. Do you remember if they considered their ability to provide medical health care programming and mental health care programming?

A. It did not specifically deal with those subjects. It dealt with what it says here, and that is operated safely and providing programming for every inmate consistent with the inmate's ability. What it was pretty much directed to were rehabilitative programs such as education and substance abuse and other types of programs, not specifically directed toward medical, mental health or dental services.

EXHIBIT 28

Deposition of Deborah Hysen
September 3, 2008
(Phase II Designations)

Part A

* * *

[43] * * *

Q. So the 6,700 infill beds that CDCR intends to build in Phase 1, those, under the current plans, would not be fully occupied until possibly June 2013. Is that right?

A. That's correct.

Q. And only 1,000 beds would be occupied as early as the 2009-2010 fiscal year?

A. That's right.

[55] * * *

Q. Looking at the dates again on Exhibit 3 that we have been talking about, the revised infill bed plan dates, CDCR's current plans for occupancy for infill beds, are you confident that these dates will be met and occupancy will be met, as noted on this chart?

A. It's all predicated on funding. There's been quite a dialogue about the funding requirements when you look at both the receiver's requested funds and CDCR's authorized funds. So this is predicated on getting the funding to do that, clearly.

EXHIBIT 28

Deposition of Deborah Hysen
September 3, 2008
(Phase II Designations)

Part C

* * *

[118] * * *

Q. Other than the 500 beds at NCRF, you don't know where the other reentry beds will be located. Right?

A. Not with certainty.

Q. Okay. And why don't You step through—you already stepped through the process for converting NCRF, which was already CDCR owned.

Can you step through the process you would have [119] to undergo with these county locations.

A. Probably the only unique aspect is the acquisition of land. So you go through a separate action through the public board of works called a site selection process, where you identify the land that you're interested in acquiring and you establish the fair market value. Part of the due-diligence effort we're engaged in right now is to assess the liability of the land, and an analysis of the fair market value. Site selection Process is really the only unique step. Otherwise, getting community collaboration and support, going through an EIR, designing, building, all that's relatively the same.

Q. So what is the anticipated date that any reentry facility other than NCRF will be occupied?

A. We have not really established those timelines yet. We are hoping to go for site selection on three sites in the fall of this year.

* * *

[120] * * *

Q. So you don't know when any reentry beds other than the first 500 will be built?

A. Not with a date certain that I can give you at this point.

Q. But It will take at least years before occupancy, correct?

A. At this point we're looking at raw land. There are a couple of sites that could offer up a renovation alternative. But anticipating that we get raw land for these first sites, we could be looking at several years between the time that we make this recommendation to acquire the land, and occupancy.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,

vs.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TWENTY-FIRST MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS, POLICIES, AND PROTOCOLS

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[ii] TABLE OF ABBREVIATIONS/ACRONYMS

3CMS:	Correctional Clinical Case Manager System
ACH:	Acute Care Hospital
ADA:	Americans with Disabilities Act
ADD:	Attention Deficit Disorder
ADHD:	Attention Deficit Hyperactivity Disorder
ADLs:	Activities of Daily Living
AED:	Automatic External Defibrillator
ambu bag:	Ambulatory Bag Used for CPR
APP:	Acute Psychiatric Program
ASH:	Atascadero State Hospital
ASMHS:	Administrative Segregation Mental Health Services
ASP:	Avenal State Prison
ASU:	Administrative Segregation Unit
BLS:	Basic Life Support
BMU:	Behavior Modification Unit
BPT:	Board of Prison Terms
C-file:	Central File
C&PP:	Clinical Policy and Programs
C&PR:	Classification and Parole Representative
Calipatria:	Calipatria State Prison
CAP:	Corrective Action Plan
[iii] CAT II:	Category II

CC:	Correctional Counselor
CCAT:	Coordinated Clinical Assessment Team
CCC:	California Correctional Center
CCI:	California Correctional Institution
CCM:	Clinical Case Manager
CCPOA:	California Correctional Peace Officers Association
CCWF:	Central California Women's Facility
CDCR:	California Department of Corrections and Rehabilitation
Centinela:	Centinela State Prison
CHCFs:	California Health Care Facilities
CHSC:	Central Health Services Center
CIM:	California Institution for Men
CIW:	California Institution for Women
CM:	Case Manager
CMC:	California Men's Colony
CMF:	California Medical Facility
CMO:	Chief Medical Officer
CNA:	Certified Nursing Assistant
CO:	Correctional Officer
CPER:	Clinical Performance Enhancement and Review Subcommittee
CPR:	Cardiopulmonary Resuscitation
CRC:	California Rehabilitation Center

CSATF:	California Substance Abuse Treatment Facility
CSH:	Coalinga State Hospital
[iv] CSP/Corcoran:	California State Prison, Corcoran
CSP/LAC:	California State Prison, Los Angeles County
CSP/Sac:	California State Prison, Sacramento
CSP/Solano:	California State Prison, Solano
CSR:	Classification Staff Representative
CTC:	Correctional Treatment Center
CTF:	Correctional Training Facility/ Soledad
CTQ:	Confined To Quarters
CVSP:	Chuckawalla Valley State Prison
CYA:	California Youth Authority
DA:	District Attorney
DAI:	Division of Adult Institutions
DCHCS:	Division of Correctional Health Care Services
DDP:	Developmental Disabilities Program
DDPS:	Distributed Data Processing System
DHS:	Department of Human Services
DMH:	Department of Mental Health
DNC:	Death Notification Coordinator

DNR:	Do Not Resuscitate
DOF:	Director of Finance
DOM:	Department Operations Manual
DON:	Director of Nursing
DOT:	Direct Observation Therapy
DRC:	Death Review Coordinator
[v] DRMC:	Delano Regional Medical Center
DSM:	Diagnostic and Statistical Manual
DTP:	Day Treatment Program
DVI:	Deuel Vocational Institution
EOP:	Enhanced Outpatient Program
EPPD:	Earliest Possible Parole Date
EPRD:	Earliest Possible Release Date
ERDR:	Emergency Response and Death Review Committee
ERRC:	Emergency Response Review Committee
ERV:	Emergency Response Vehicle
ETV:	Emergency Transport Vehicle
FIT:	Focus Improvement Team
Folsom:	Folsom State Prison
FPTTP:	Foreign Prisoner Transfer Treaty Program
FTE:	Full-Time Equivalent
GACH:	General Acute Care Hospital
GAF:	Global Assessment of Functioning

GP:	General Population
HCCUP:	Health Care Cost and Utilization Program
HCM:	Health Care Manager
HCPOP:	Health Care Placement Oversight Program
HCPU:	Health Care Placement Unit
HCQMC:	Health Care Quality Management Committee
HDSP:	High Desert State Prison
HQ:	Headquarters
[vi] HS:	*Hora Somni*/Hour of Sleep
ICC:	Institutional Classification Committee
ICF:	Intermediate Care Facility
ICP:	Intermediate Care Program
ICU:	Intensive Care Unit
IDTT:	Interdisciplinary Treatment Team
IEX:	Indecent Exposure
IMHIS:	Inmate Mental Health Information System
IMSP:	Inmate Medical System Policy
INS:	Immigration and Naturalization Service
IP:	Inmate Profile
I/P:	Inmate/Patient
ISP:	Ironwood State Prison

IST:	In-Service Training or Incompetent to Stand Trial
ISU:	Investigative Services Unit
KOP:	Keep on Person
KVSP:	Kern Valley State Prison
LCSW:	Licensed Clinical Social Worker
LLE:	Language Learning Enterprises
LOC:	Level of Care
LOP:	Local Operating Procedure
LOU:	Locked Observation Unit
LPN:	Licensed Practical Nurse
LPT:	Licensed Psychiatric Technician
[vii] LSW	Limited suicide watch
LVN:	Licensed Vocational Nurse
MAR:	Medication Administration Record
MCSP:	Mule Creek State Prison
MDD:	Major Depressive Disorder
MDO:	Mentally Disordered Offender
MERD:	Minimum Eligible Release Date
MH-4:	Mental Health Assessment
MHCB:	Mental Health Crisis Bed
MHOHU:	Mental Health Outpatient Housing Unit
MHP:	Mental Health Program
MHQMS:	Mental Health Quality Management System

MHS:	Mental Health Subcommittee
MHSDS:	Mental Health Services Delivery System
MHSPC:	Mental Health Suicide Prevention Coordinator
MHSR:	Mental Health Suicide Reviewer
MHTS:	Mental Health Tracking System
MOD:	Medical Officer of the Day
MOU:	Memorandum of Understanding
MPIMS:	*Madrid* Patient Information Management System
MSF:	Minimal Support Facility
MTA:	Medical Technical Assistant
NAM:	Nurse Administered Medication
NCF:	Normal Cognitive Functioning
NKSP:	North Kern State Prison
[viii] NOS:	Not Otherwise Specified
NPPEC:	Nursing Professional Practice Executive Committee
NVDRS:	National Violent Death Reporting System
OCD:	Obsessive Compulsive Disorder
OHU:	Outpatient Housing Unit
OIA:	Office of Investigative Affairs
OJT:	On the Job Training
OP:	Operating Procedure
OSS:	Office Services Supervisor

OT:	Office Tech
PBSP:	Pelican Bay State Prison
PC:	Primary Clinician
PHU:	Protective Housing Unit
PIA:	Prison Industry Authority
POC:	Parole Outpatient Clinic or Psychiatrist on Call
POD:	Psychiatrist on Duty or Psychiatrist of the Day
PPE:	Personal Protective Equipment
PPEC:	Professional Practice Executive Committee
PPRC:	Psychological Peer Review Committee
PSH:	Patton State Hospital
PSU:	Psychiatric Services Unit
PSW:	Psychiatric Social Worker
psych tech:	Licensed Psychiatric Technician
PT:	Licensed Psychiatric Technician
[ix] PTSD:	Post Traumatic Stress Disorder
PVSP:	Pleasant Valley State Prison
QIP:	Quality Improvement Plan
QIT:	Quality Improvement Team
QMAT:	Quality Management Assessment Team
QMC:	Quality Management Committee
QMT:	Quality Management Team
QNC:	Quality Nurse Consultant

R&R:	Receiving & Release/Reception and Receiving
RC:	Reception Center
RJD:	Richard J. Donovan Correctional Facility
RN:	Registered Nurse
RT:	Recreation Therapist
RVR:	Rule Violation Report
SCC:	Sierra Conservation Center
SHU:	Security Housing Unit
SI:	Suicidal Ideation
SMTA:	Senior Medical Technical Assistant
SMY:	Small Management Yard
SNF:	Skilled Nursing Facility
SNY:	Sensitive Needs Yard
SOA&P:	Subjective Objective Assessment and Plan
SPC:	Suicide Prevention Committee
SPRFIT:	Suicide Prevention and Response Focused Improvement Team
SPU:	Special Processing Unit
[x] SQ:	San Quentin State Prison
SRA:	Suicide Risk Assessment
SRAC:	Suicide Risk Assessment Checklist
SRC:	Suicide Review Committee
SRN:	Senior Registered Nurse
SSA:	Staff Services Analyst

SSI:	Supplemental Security Income
SVP:	Sexually Violent Predator
SVPP:	Salinas Valley Psychiatric Program
SVSP:	Salinas Valley State Prison
TCMP:	Transitional Case Management Program
THU:	Transitional Housing Unit
TLU:	Transitional Living Unit
TPU:	Transitional Program Unit or Temporary Protective Unit
TTA:	Triage and Treatment Area
UCC:	Unit Classification Committee
UCSF:	University of California at San Francisco
UHR:	Unit Health Records
UNA:	Unidentified Needs Assessment
VSPW:	Valley State Prison for Women
VPP:	Vacaville Psychiatric Program
WHO:	World Health Organization
WSP:	Wasco State Prison

* * *

[375] SUMMARY

Staffing:

As of October 31, 2008, the vacancy rate in mental health staffing[5] at CDCR institutions continued the decline that had been found during the preceding monitoring period. The only exceptions to this trend were for senior psychologists, for whom the earlier vacancy rate of 12 percent increased slightly to 13 percent, and for psych techs, whose vacancy rate remained the same at 19 percent.

The total number of established mental health positions for chief, senior, and line psychiatrists; chief, senior, and line psychologists; clinical social workers; psych techs; and recreation therapists was 2,126.2. Of these positions, 1,711.85 were filled by full-time employees. The collective vacancy rate for all of these positions was 19 percent, as compared to the vacancy rate of 28 percent during the preceding monitoring period. With use of contractors, the functional vacancy rate for all of these mental health disciplines was reduced to 11 percent, which was an improvement over the twentieth monitoring period's mental health functional vacancy rate of 17 percent.

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[5] Source of staffing data reported in this section: *CDCR Secured FTP Website for Monthly Reports*, posted on November 26, 2008, covering the month of October 2008. Defendants stated on page three of their January 6, 2009, response to this Court's Order of October 8, 2008, that their posting of three *Coleman* Monthly Reports has drawn a total of 20 "hits," of which six were by plaintiffs' counsel, and that "only the plaintiff's attorneys have consistently retrieved every report." Contrary to defendants' implication that their web-posted monthly report is rarely used by the Special Master, it was used extensively to measure defendants' compliance with staffing requirements discussed in this Report.

For the 188.2 chief and supervising psychiatrist and psychologist positions, the vacancy rate was 14 percent. No contractors were used to cover any of these vacancies. Among the 1,938 line mental health staff positions, there were 387.4 unfilled positions, for a vacancy rate of 20 percent. Use of contractors reduced the functional vacancy rate among all line mental health positions to 11 percent.

[376] There was significant improvement with staffing chief and supervising psychiatrist positions. The vacancy rate for chief psychiatrists dropped from 42 percent to 16 percent since the preceding monitoring period. The only institutions that did not fill their chief psychiatrist allocations were CRC, CSP/LAC, ISP, and SQ.

Although staffing of senior psychiatry allocations improved over the vacancy rate of 47 percent in the preceding monitoring period, it stood out as the least successful with staffing among all disciplines, with a vacancy rate of 38 percent. Institutions that had one or more unfilled senior psychiatry positions were CCI, CMF, CMC, CRC, CSP/Corcoran, CSP/LAC, CCWF, and SQ, none of which used contractors to cover these vacancies.

For chief psychologist positions, the earlier but already-low overall vacancy rate of eight percent during the preceding monitoring period was surpassed, with full employment in these positions and no contractual assistance required.

For senior psychologist positions, the vacancy rate at 13 percent was marginally higher than it was during the preceding monitoring period, when it was

12 percent. Seventeen institutions filled all of their posts for senior psychologists. CMC, CSP/LAC, CSP/Sac, DVI, and RJD had vacancy rates ranging from seven percent to 14 percent, while CMF, HDSP, PBSP, PVSP, SVSP, and VSPW had vacancy rates ranging from 17 percent to 25 percent. ASP, CCWF, SQ, and CSP/Solano had the highest vacancy rates, at 50 percent for both ASP and CSP/Solano, 44 percent for CCWF, and 36 percent for SQ. No contractors were used to cover senior psychologist vacancies at any of the institutions.

Filling line psychiatry positions has posed the biggest challenge to CDCR mental health staffing in recent years. Since the preceding monitoring period, the vacancy rate was reduced from 51 percent to 33 percent. With use of contractors, the functional vacancy for line [377] psychiatry rate dropped to only six percent. Twelve institutions filled all or nearly all of their line psychiatry allocations with full-time psychiatrists, while 19 institutions were able to fill some of their psychiatry allocations with full-time employees. ASP, CCI, CIM, CSP/Solano, CTF, PVSP, SQ, and WSP were able to achieve full or near-full coverage with contractual assistance. CMF, CRC, CSP/LAC, CSP/Corcoran, CSP/Sac, CSATF, Centinela, CVSP, HDSP, PBSP, and SVSP lowered their functional vacancy rates to a range of 14 percent to 45 percent. CCC and ISP and had functional vacancy rates of 100 percent and 61 percent, respectively.

In line psychology, the earlier systemwide vacancy rate of 27 percent was reduced during this monitoring period to 18 percent. Use of contract psychologists lowered the functional vacancy rate to six percent. Those institutions that filled or nearly filled their line psychology positions with full-time employees were

ASP, CIM, CIW, CMF, CRC, CSP/Sac, CSATF, CTF, DVI, Folsom, RJD, SQ, and WSP. With use of contractors, another group of institutions, CCI, CMC, CSP/Solano, Centinela, ISP, KVSP, MCSP, PBSP, PVSP, and SVSP, achieved full or near-full coverage by using contractors. However, CSP/LAC, Calipatria, and HDSP had functional vacancy rates in the range of 26 to 33 percent, while functional vacancy rates at CCWF and CCC were 41 percent and 69 percent, respectively.

The institutions fared well overall with filling and covering social work positions, with an overall vacancy rate of 11 percent, and a functional vacancy rate of five percent with use of contractors. In the preceding monitoring period, the vacancy rate was 18 percent, and with use of contractors, the functional vacancy rate was reduced to eight percent. A total of 15 institutions filled all of their social work positions with full-time employees, and another three institutions were able to keep their vacancy rates under ten percent. With use of contract social workers, two more institutions fully covered their allocations in this discipline. The remaining [378] ten institutions that employ social workers had functional vacancy rates of 26 percent or less. These institutions were ASP, CIW, CMF, CMC, KVSP, CSP/Corcoran, CSP/Sac, SVSP, SQ, and VSPW. The institution that fared the poorest was CRC, with a functional vacancy rate of 50 percent.

Insofar as coverage of psych tech positions, the institutions continued to use contractors very sparsely. Only 2.4 full-time equivalent psych tech contractors were used, which was not enough to nudge the preexisting psych tech vacancy rate of 19 percent any lower. CIW was the only institution that filled all of its psych tech positions with full-time employees, and CTF almost achieved that status with a vacancy rate of only one percent. Another seven institutions, CSP/Corcoran, CSATF, MCSP, NKSP, SVSP, SQ, and SCC, managed to keep their vacancy rates under ten percent. Among the remaining 24 institutions, 14 kept their vacancy rates under 30 percent. These institutions were ASP, CCC, CIM, CMF, CMC, CSP/LAC, CSP/Sac, CSP/Solano, Centinela, CCWF, CVSP, DVI, KVSP, and WSP. Vacancy rates ranged from 30 percent to 42 percent at CCI, CRC, Calipatria, HDSP, PBSP, PVSP, RJD, and VSPW. Folsom had no coverage for its sole .75 psych tech position. ISP covered only 61 percent of its psych tech allocations.

The vacancy rate for recreation therapist positions was 25 percent, and scant use of contractors lowered the functional vacancy rate by only two percent. Among the 29 institutions that employ recreation therapists, ten had vacancy rates under ten percent. Apart from a group of 12 institutions that filled up to half of their recreation therapist positions, there were seven institutions that had no coverage at all for any of their recreation therapist positions, yielding vacancy rates of 100 percent. These seven institutions were CRC, CTF, DVI, Folsom, HDSP, PVSP, and SCC.

[379] Quality Management:

During the monitoring period, the quality management processes at CIW, CSP/Sac, CSP/Solano, DVI, Folsom, and PVSP continued to function. At ASP and CTF, the process continued to improve, but did not achieve full compliance. SCC's proactive quality assurance program provided the engine for continued program improvements, resulting in the resolution of four CAP items during the preceding reporting period, and another five items during the current monitoring period. The institutional approach to quality management at MCSP continued to be mixed. The quality assurance program was revitalized under the guidance of new mental health leadership at CCWF. At CIW, an access-to-care committee comprised of mental health, medical, and custody personnel was established to address issues related to mental health care and custody interface. CMF broadened the focus of quality management to encompass quality of care.

During the monitor's site visits, a number of concerns were noted. At CVSP and Calipatria, quality management activities consisted primarily of UHR audits. Due to lack of clear leadership in mental health at Calipatria, quality management was generally not fully functioning. Other than suicide prevention, LOPs at Calipatria were not updated or revised to reflect Program Guide revisions, and the LOPs for administrative segregation, OHU, and referrals had not been updated since 2006/2007. At CMF, treatment providers reported that information about the issues they faced was rarely addressed via the quality management process. Mental health line staff at CSP/Corcoran reported that they received no feedback regarding the quality management process and had only limited participation in the quality management process through peer review.

[380] During the monitoring period, the local governing bodies of CSP/Corcoran and MCSP met monthly. CSP/Solano's local governing body reportedly met in April 2008, and PBSP's local governing body met twice during the first six months of 2008. The local governing body at CSP/Sac met quarterly, and the one at PVSP met regularly. The local governing bodies at PVSP and PBSP maintained minutes.

Although the local governing body at CSP/Corcoran maintained minutes that were sparse in content, agendas were detailed. Minutes were not available for local governing body meetings at CSP/Solano and CRC. Local governing body meetings at CSP/Corcoran were routinely attended by custody, medical, and mental health supervisors. The membership of CRC's local governing body consisted of the warden and CMO. PBSP's local governing body meeting minutes indicated that mental health was represented and mental health issues were addressed.

The quality management committees of ASP, CSP/Solano, CSATF, KVSP, and WSP met regularly, and CRC's quality management committee met biweekly. Quality management committees at CCC, CSP/LAC, CTF, Folsom, and SQ met weekly, while at CMC and CSP/Sac, they met monthly. The quality management committee at CSP/Corcoran generally met monthly, and the ones at CCWF and CIW met twice a month. MCSP's quality management committee met sporadically, but at least twice each month, and showed significant improvement since the preceding monitoring period. The quality management committee meetings at ASP, CMC, CCWF, CRC, CSATF, CTF, DVI, Folsom, MCSP, SQ, and VSPW were well attended. CSP/LAC's quality management committee meetings were well attended by necessary clinical staff, but custody staff did not regularly attend. The quality management committees at CCWF, CRC, CSATF, CTF, DVI, MCSP, SQ, VSPW, and WSP kept minutes, but the one at KVSP did not.

[381] The mental health subcommittees at CCI and CMC met biweekly, while at CSP/Sac, PBSP, and SQ, mental health subcommittees met weekly. At CSP/Corcoran, CCWF, CIW, and CSATF, mental health

subcommittees met twice per month. The mental health subcommittees of ASP, CIM, CMF, CRC, CVSP, HDSP, and SCC met at least monthly, and CTF's mental health subcommittee met bimonthly. Meetings of the mental health subcommittees at CMC, CCWF, CRC, CSATF, CTF, SCC, and SVSP were well attended, but WSP's mental health subcommittee did not include non-supervisory members. At PBSP, attendance for required participants at mental health subcommittee meetings improved significantly. CTF also had increasing levels of participation. At Calipatria, only 38 percent of the mental health subcommittee meetings achieved a quorum. CVSP's mental health subcommittee meetings never attained a quorum, and custody staff attendance was consistently poor. At HDSP's mental health subcommittee meetings, attendance ranged from six to eight mental health staff members, and custody was generally unrepresented. Toward the end of the monitoring period, SCC's mental health subcommittee minutes showed that attendance had improved to about 70 percent of required attendees present at meetings.

CMC, CSP/Corcoran, CCWF, CRC, CSATF, CTF, HDSP, PBSP, SCC, and VSPW kept minutes for the mental health subcommittee meetings. KVSP did not provide meeting minutes. CTF minutes showed a need for greater focus on problem solving and documentation of decisions made. SCC's mental health subcommittee meetings appeared to double as staff meetings, with a substantial portion of the meetings dedicated to routine exchange of information.

Throughout the monitoring period, several institutions chartered and used QITs appropriately and effectively. Institutions that chartered QITs to address substantive mental [382] health issues included ASP, CCI, CIM, CSP/Solano, CTF, DVI, HDS, PBSP, SCC, and VSPW. At PVSP, four QITs were chartered to address medication management issues, but none were chartered to address other mental health issues, although issues with confidentiality of mental health contacts, increased group treatment, and transporting of medical records could have benefitted from QITs. At WSP, there were three QITs, but only the medication management QIT was fully active. CSP/Corcoran had three active QITs, SQ had 14, and SVSP had two. At RJD, two mental health QITs were active, although an audit schedule was implemented for all key program areas to monitor identified problems concurrent with QITs. At CCWF, QITs were chartered to resolve issues related to UHR availability and timely completion of initial clinical intake assessments and IDTT meetings.

At CSP/LAC, there were only two active QITs at the time of the monitor's visit, both mandated by headquarters. The MHTS QIT was functionally impotent due to lack of technical support and significant limitations inherent in the MHTS. The administrative segregation EOP QIT was also problematic because of the lack of clarity regarding the goals for the QIT.

At CVSP, no QITs were chartered, nor had the action-item list attached to the meeting minutes been updated or revised for six months. KVSP provided documentation indicating that it had not chartered, sustained, or completed any QITs during the reporting period. CSATF chartered QITs when needed, but none were active at time of the monitor's visit. Managers reported that recently identified problems were resolved by directives and supervision. At CSP/Sac, there were indications QITs were not fully utilized to identify and deal with problems encountered by treatment providers. At CRC, staff reported that QITs were not [383] routinely used and that significant problems with mental health during the preceding few months had been resolved without QITs.

At ASP, CMF, CSATF, HDSP, MCSP, NKSP, PVSP, SCC, and SQ, routine audits occurred regularly and were integral to the quality management system. With the exception of medication audits, DVI similarly conducted useful quality management audits.

Audit methodology and accuracy improved at CCWF. A newly established quality assurance analytical unit had begun to systematically collect and analyze performance data from each program area to timely identify problems and devise strategies for improvement. At WSP, with only one exception, audits of MHSDS indicators were characterized by small sample sizes and long intervals between audits. At PBSP, staff reported difficulties with collecting and interpreting audit results from nursing staff. No standardized auditing, analyzing, or reporting methodologies were used, and no effective system was in place to ensure audit results were reported back for quality improvement and corrective action as necessary. RJD's audit items were tracked at the QMC meetings, but presentation of the results to the QMC for analysis, discussion, and necessary follow-up was not consistent.

At CIM, CIW, CMC, CSP/Corcoran, CSP/LAC, CSP/Sac, DVI, Folsom, PBSP, and RJD, an active peer review process was in place for psychiatrists, psychologists, and social workers. PBSP had significant improvement in its peer review process for clinical staff and an active process in place for psych techs. At CIM, however, there continued to be significant problems with quality of the process, frequency, and the limited number of clinicians involved in the peer review process. Although showing improvement in form, CSP/LAC focused more on the presence or absence of criteria rather than qualitative review. At CCI, Centinela, MCSP, PVSP, and SVSP, psychiatry and psychology engaged in peer review. At CRC, peer review for [384] psychologists and case managers occurred. At NKSP, psychiatry conducted peer review, as did psychologists and social workers in a combined case manager review format. At CSP/Corcoran, the psychologist peer review committee provided summaries of each meeting, but the social work peer review committee failed to keep minutes or summaries. Peer review at CCI, CRC, and PVSP maintained records of activities.

At RJD, the audit tool developed and implemented by the peer review coordinator was primarily a quality assurance instrument that focused on the presence or absence of various items in the UHR. CCI limited its peer review process to records only. At VSPW, the peer review process was evolving and needed to be strengthened in each discipline, particularly in psychiatry. Documentation that peer review was intra-disciplinary and not interdisciplinary needed to be clearly spelled out, as did the requirements of appropriate peer review reports.

Mental health staff were not engaged in peer review at CSATF. Peer review at CCWF and WSP was not fully functional, and was not occurring at all at CSP/Solano. At CTF, peer review processes for both psychiatrists and psychologists needed to be expanded beyond examination of UHRs for presence of required documentation. Peer review for psychiatrists was not yet established at SCC.

Suicide Prevention:

Over one third of institutional SPCs satisfied Program Guide requirements, with regular meetings, pertinent agenda items, and appropriate attendance. These institutions included ASP, CIM, CIW, CMC, CSP/Corcoran, CSP/Sac, CSATF, CCWF, CSP/Solano, Folsom, NKSP, and PVSP. While CCI, CMF, CRC, CSP/LAC, CTF, Calipatria, Centinela, CVSP, PBSP, RJD, SCC, SQ, and WSP satisfied requirements for regular meetings, substantive agenda items, and maintaining of minutes, they continued to struggle to achieve adequate [385] attendance by all disciplines. The SPCs at HDSP and VSPW met regularly with appropriate disciplines, but meetings were *pro forma* and lacked substantive content. MCSP's SPC met regularly, although committee attendance was poor and failed to discuss implementation of plans, recommendations, or outcomes related to suicide prevention.

Institutional ERRCs were fully implemented and functioned well at ASP, CIM, CSP/LAC, PBSP, and PVSP. CSP/Corcoran had a fully functioning committee, but documentation needed improvement. Similarly, SVSP's committee, while fully implemented, did not have a standardized review process for suicide attempts. VSPW's ERRC meetings were *pro forma* and perfunctory. At DVI and Folsom, the ERRCs failed to meet regularly and were poorly attended by all required disciplines.

One quarter of the institutions completed CPR training for nearly all custody staff. These institutions included CSP/LAC, CSP/Solano, CCWF, CVSP, Folsom, HDSP, MCSP, PBSP, and RJD. Monthly medical emergency response drills in administrative segregation units were performed at ASP, CMF, CSP/LAC, CSP/Sac, CSP/Solano, CSATF, CCWF, CVSP, HDSP, and SVSP. At Folsom, psych techs did not participate, and at MCSP, the drills did not include scenario enactment.

One third of the institutions were compliant with five-day follow-up of inmates discharged from an MHCB or, in some instances, returned from DMH. These institutions included ASP, CSATF, CVSP, DVI, Folsom, KVSP, NKSP, PVSP, RJD, SQ, and SCC. CSP/LAC was substantially compliant, even though tasked with following up on approximately 100 cases per month. CMC did not track completion of five-day follow-up and custody observation, but an audit yielded a compliance rate of 75 percent for clinical follow-up of inmates in administrative segregation. At CSP/Solano, weekend and holiday follow-up was not [386] consistent by clinical and custody staff alike. WSP was noncompliant for completion of both mental health follow-up and custody observation.

Custody observation was completed as required at HDSP, although mental health follow-up was not. Likewise, custody observation was substantially compliant at CMF and PBSP, but was noncompliant at CIW, CTF, and Centinela.

All institutions demonstrated at least some degree of implementation of the Department's plan to reduce suicides in administrative segregation. ASP, CIW, CMF, CRC, CSP/Sac, CCWF, Folsom, NKSP, PVSP, and SCC included in their initial screening process the inmate history section of the MHTS inmate profile, which contains information about past suicidal behavior. CVSP implemented the inmate profile toward the end of the monitoring period. CSP/LAC was unable to generate inmate profiles due to limitations with information technology.

Half of the institutions administered the preplacement screens for suicidal behavior to inmates newly arriving in administrative segregation. CMF, CSP/Solano, CSATF, CVSP, CTF, DVI, Folsom, NKSP, PBSP, SQ, SCC, and VSPW were compliant with timely, confidential screens. CSP/LAC, CSP/Sac, and RJD completed the screens at cell-front. CMC screened only 77 percent of new arrivals into administrative segregation, while Centinela experienced difficulties with documentation. ASP, CIW, and Calipatria were noncompliant with completion of screens.

Nearly 70 percent of the institutions completed post-placement 31-question screens. ASP, CIW, CMF, CMC, CSP/Solano, CSATF, CCWF, DVI, HDSP, KVSP, MCSP, NKSP, PBSP, PVSP, SVSP, SQ, and VSPW were compliant for timely completion in a confidential setting and filing in UHRs. CSP/LAC, CSP/Sac, and RJD were timely with this task [387] but completed the screens at cell-front. CIM's documentation was incomplete, with the inmate's date of arrival at administrative segregation routinely missing. Folsom fell short on timeliness. CCI, CTF, and SCC were not compliant with completion of post-placement screens.

Retrofitting of administrative segregation intake safety cells was completed at one third of the institutions. These institutions included ASP, CSP/LAC, CSP/Sac, Calipatria, Centinela, CCWF, HDSP, KVSP, NKSP, RJD, and VSPW. CMF, CSP/Solano, and SCC completed the renovations, but the cells were not used regularly for newly arriving inmates. CSATF, CTF, and Folsom were in the process of retrofitting cells. Although SQ renovated cells, problems with the doors rendered the cells unusable for new arrivals. PBSP and PVSP did not retrofit any cells for intake of new arrivals in administrative segregation, but utilized placards to identify these cells.

Custody 30-minute welfare checks were completed at over 70 percent of the institutions. Forty-two percent of the institutions achieved full compliance with documented staggered checks during the first 21 days of an inmate's stay in administrative segregation. ASP, CIM, CIW, CMC, CSP/Corcoran, CSP/Solano, Centinela, Folsom, HDSP, NKSP, PBSP, PVSP, and VSPW were all in compliance. CSATF, KVSP, MCSP, RJD, SVSP, SQ, and SCC completed the welfare checks, but they were not staggered appropriately. CMF adequately completed welfare checks in three of its four administrative segregation units. CCI, CSP/LAC, CSP/Sac, and CCWF were noncompliant with completion of 30-minute welfare checks for new arrivals in administrative segregation.

The proportion of institutions that complied with documented daily psych tech rounding decreased from 70 percent to 60 percent during the monitoring period. ASP, CIM, CIW, CMF, CMC, CSP/Sac, CSP/Solano, CSATF, Centinela, CTF, Folsom, HDSP, MCSP, [388] NKSP, PBSP, PVSP, SVSP, SQ, SCC, and VSPW all demonstrated compliance. Psych tech rounds were completed at CCI and CCWF, but documentation was poor.

Provision of out-of-cell exercise for inmates housed in segregated housing remained difficult at nearly 60 percent of the institutions. CMF, CSP/Corcoran, CSATF, Calipatria, CCWF, CTF, Folsom, HDSP, MCSP, SVSP, SQ, SCC, and VSPW offered ten hours per week of out-of-cell exercise. NKSP offered ten hours, but these often occurred simultaneously with offers of group therapy. PBSP was partially compliant, offering seven hours per week. CCI, CIM, CSP/LAC, CSP/Solano, Centinela, DVI, PVSP, and RJD were noncompliant, largely due to the lack of yard space, particularly walk-alone yards.

Forty percent of the institutions fulfilled their minimum requirement of implementing a morning "check-in" meeting among an administrative segregation unit sergeant and designated mental health personnel. ASP, CCI, CSP/LAC, CSP/Sac, CSATF, CCWF, CVSP, DVI, Folsom, HDSP, PBSP, RJD, SQ, and VSPW all demonstrated compliance.

Nearly 70 percent of the institutions explored the feasibility of providing access to electricity within cells for electrical appliances within cells for non-disciplinary inmates in administrative segregation. Inmates at CIW, CSP/Sac, CSATF, CCWF, CTF, HDSP, PBSP, SVSP, and VSPW had access to electrical appliances. There were no electrical outlets in the administrative segregation cells at ASP, CIM, CMF, CMC, CSP/LAC, CSP/Solano, Calipatria, Folsom, NKSP, RJD, SQ, SCC, and WSP.

Medication Management:

Medication Management Data and Auditing Transition Issues

During the course of the twenty-first monitoring period, institutions were faced with a number of transition issues that affected medication administration and audits of [389] medication-related functions. Principally, transition issues involved the initiation of the Maxor pharmacy management information system in pharmacies throughout CDCR and the shifting of responsibility for medication management audits to nursing. These developments affected medication data and audits at several institutions. Medication management auditing was temporarily impeded by the introduction of the Maxor system at CIW, CSP/Sac, CSATF, HDSP, PBSP, PVSP, SQ, and WSP. It was anticipated that these issues would be resolved as the institutions became acclimated to these new systems.

All institutions planned to eventually shift responsibility for medication management from mental health to nursing. Responsibility for conducting medication management audits was shifted from mental health staff to nursing at CCI, CRC, DVI, SCC, and SQ, which similarly had growing pains. A number of institutions, including ASP, Centinela, Folsom, PBSP, SVSP, and VSPW, made significant changes to their medication management auditing systems and methodologies, while several others continued to struggle. There were some institutions that did not provide medication management audits, or produced partial audits that did not cover required substantive medication areas, or produced audit results that were methodologically flawed. These institutions included Calipatria, CCI, CIM, CMC, CRC, CSP/LAC, CSP/Solano, CCWF, DVI, KVSP, and SQ. The Special Master is working closely with nursing staff to develop and refine medication management audit tools to improve performance in this area.

Issues surrounding medication management data and audits, as well as the overlapping responsibilities for psychotropic medication management in both mental health programs and medical services, led to the establishment of a work group on nursing audits of [390] medication management within the ongoing coordination process among the *Armstrong*, *Coleman*, *Perez*, and *Plata* cases.

Medication Continuity for Newly Arriving Inmates

An increased number of institutions were compliant with continuing medication for newly arriving inmates by providing the first doses within 24 hours of arrival. CIW, CSP/Corcoran, CRC, and CVSP maintained compliance, while ASP, CSP/LAC, CCWF, and SVSP achieved compliance. There was significant improvement with medication continuity for arriving inmates at CSP/LAC, NKSP, PBSP, and WSP. NKSP and MCSP were both close to compliance.

CIM, CSP/Sac, and RJD were compliant with continuing medications without interruption for inmates who arrived with verified medication orders from other CDCR institutions or county jails. CIM and RJD achieved noted improvement in medication continuity for inmates newly arriving with unverified medication orders. VSPW similarly maintained compliance with medication continuity for newly arriving inmates at its reception center, but had a measure of difficulty meeting the same standard for arriving non-reception center inmates. Centinela was compliant with meeting medication continuity for inmates arriving during the workweek, but had problems with new arrivals during weekend days. CMC did not audit arrival medication continuity.

A number of institutions did not meeting the standard for continuing medications of arriving inmates. These institutions included Centinela, CCI, CSATF, CTF, DVI, HDSP, PBSP, PVSP, and CSP/Solano. SQ continued to have problems with medication management audits, including those for medication for newly arriving inmates. SCC, which was previously [391] compliant, did not provide data concerning this item. CMC did not perform audits regarding medication continuity for arriving inmates.

Medication Continuity on Intra-Institutional Transfers

Compliance with continuity of medications following housing changes within the same institution was maintained or achieved by ASP, CCWF, CSP/Corcoran, NKSP, RJD, SCC, SVSP, and VSPW. RJD and SVSP also achieved medication continuity upon discharge from an MHCB or OHU. Marked improvements in medication continuity upon housing transfer were noted at CCI and WSP, although they did not reach compliance. CSP/Corcoran remained noncompliant but showed notable improvement.

Medication continuity following intra-institutional transfers was problematic at CIW, CSP/LAC, CSP/Solano, CSATF, CCWF, DVI, Folsom, HDSP, MCSP, PVSP, and SQ. KVSP did not track medication continuity related to housing moves, and CRC did not conduct audits of medication continuity upon intra-institutional housing changes. CTF did not provide audit data related to intra-institutional transfers.

CMF did not comply with medication continuity following discharges from inpatient care. For CMF inmates, medication continuity was not affected by intra-institutional housing changes. Medication continuity in administrative segregation at CMF conflicted with scheduled yard time.

Medication Order Renewals

Medication renewal orders were issued timely at CCI, CIM, CMC, CSP/Corcoran, CSP/Sac, CTF, Centinela, DVI, KVSP, RJD, SCC, SVSP, and WSP. ASP was nearing compliance with timely renewal of medication orders for general population inmates, and [392] attained compliance in administrative segregation. VSPW was near compliance with timely renewing medication orders.

A number of institutions were noncompliant with timely renewal of psychotropic medications. At CMF and DVI, medication renewal gaps and lapses were commonplace. There were also problems at CIW, CSATF, HDSP, PBSP, and SQ with timely renewals.

KVSP and SVSP were compliant with documenting the rationale for medication orders, including reasons for changes and discontinuations. CRC did not consistently document the rationale for medication changes.

Medication Refills

CSP/Sac, CTF, DVI, KVSP, and VSPW were compliant with timely refilling and administering medication orders. ASP was close to compliance in refilling medications in its MHSDS general population areas, but was noncompliant with timely refilling medications in administrative segregation following medication changes, reviews, and renewals. PBSP processed refill orders and administered medications appropriately during regular work hours, but was noncompliant after regular hours and on weekends and holidays. CIW, CSATF, Centinela, CVSP, DVI, HDSP, and SQ were noncompliant with appropriate delivery of medications following changes and new orders.

Medication Noncompliance

Appropriate identification, documentation, referral, and response to inmate medication noncompliance continued to be a major hurdle for a large number of institutions. CIM, CMF, CSATF, CCI, CSP/Corcoran, CSP/Sac, Centinela, Folsom, HDSP, KVSP, MCSP, NKSP, PVSP, RJD, SCC, SVSP, VSPW, and WSP did not meet standards for addressing issues of medication noncompliance.

[393] CMC, CCWF, and DVI were compliant with referrals and responsiveness to medication noncompliance. CRC revised its procedures and reported a significant decrease in incidents of medication noncompliance. PBSP instituted new medication noncompliance policies and procedures. Audits of medication noncompliance at CSP/LAC, CSP/Solano, and SQ were flawed, and CIW failed to provide audit data concerning medication noncompliance.

Pill Lines

Several institutions continued to use pill lines for medication delivery. Lengths of pill lines and waiting times were appropriate at Folsom, PBSP, and RJD. Expansion of available pill lines at CMC and Folsom accounted for improvements.

Pill line waiting times were problematic at ASP, CSP/Solano, CSATF, HDSP, and SCC. CIW developed plans for additional pill lines when waiting times frustrated access to scheduled group therapy. CCWF reported excessively long pill lines, but neither CCWF nor CSP/Corcoran conducted formal audits in this area. Despite its history of problems with pill lines, VSPW did not conduct audits on them. CRC was in the process of developing an LOP to improve pill line efficacy.

Informed Consent

CSP/Solano, DVI, PVSP, SVSP, and SCC complied with requirements regarding obtaining and maintenance of current informed medication consent faints concerning psychotropic medications. PBSP instituted new policies and procedures on informed consent and was compliant with informed consent standards.

Audits of informed consent at CSP/Sac yielded mixed results as a result of misfiled documents. WSP improved with informed consent, but continued to have problems. [394] CSP/Corcoran showed improvement as a result of increased supervision. RJD, which was previously complaint, slipped but remained very close to compliance standards.

A number of institutions were noncompliant with informed consent requirements and reported problems. These institutions included CMC, Centinela, CCWF, and NKSP. Audits of informed consent at SQ were inadequate, and at CRC, they were not done.

Laboratory Testing

Requirements for laboratory testing of blood levels for atypical antipsychotic medications were satisfied at RJD, and for mood stabilizers, they were satisfied at ASP, CMC, CTF, CCWF, RJD, SQ, and VSPW. CSP/Solano and Folsom improved but did not attain compliance. Folsom did not have in place a process to meet laboratory requirements for atypical antipsychotic medications.

Laboratory testing was problematic or noncompliant at CCC, CIM, CSP/LAC, DVI, NKSP, PBSP, SVSP, SQ, and WSP. CSP/Corcoran improved significantly, but still did not reach compliance. Laboratory tests were not ordered at Calipatria due to the short-term stay of MHSDS inmates at Calipatria. In the single instance where laboratory tests for mood-stabilizing medications were ordered at CVSP, the institution complied with requirements. CIW and SCC did not provide information regarding laboratory testing.

DOT Medication Administration

Large numbers of DOT orders at institutions raised questions whether they were supported by exercise of clinical judgment and whether adequate DOT could actually be utilized. Several institutions, including CCC, CSP/Solano, ISP, PBSP, and SCC, required that all psychotropic medications were to be administered DOT. Psychotropic medications were administered DOT at CSP/Corcoran, CSP/Sac, CCWF, and NKSP, and almost exclusively via [395] DOT at Folsom. Compliance with appropriate DOT protocols improved markedly at DVI. MCSP had some difficulties with DOT, but satisfied compliance requirements. CTF and KVSP ordered medications DOT, but did not present audit data related to the area. ASP was in the process of transitioning away from inappropriate DOT orders.

CSP/LAC, CSATF, Folsom, PVSP, RJD, and SVSP ordered medications DOT, but did not comply with required protocols. SQ was unable to generate a DOT list. At WSP, DOT medication administration was indistinguishable from nurse-administered medication. CRC ordered DOT medications for inmates who were medication noncompliant or suspected of noncompliance.

Keyhea Process

A number of institutions appropriately used the Keyhea process, including ASP, CIW, CMC, CSP/Corcoran, CSP/Sac, CSATF, CCWF, KVSP, NKSP, PBSP, RJD, and SVSP. CRC and VSPW immediately transferred their Keyhea inmates to other institutions. The Keyhea process improved at SQ, but remained problematic at CIM, DVI, Folsom, and WSP. CSP/LAC did not track Keyhea orders.

Support from CDCR's Division of Legal Affairs in the Keyhea process was generally reported to be beneficial across institutions.

HS Medications

Institutions that appropriately utilized HS medication orders included CIM, CIW, CSP/Corcoran, CTF, CCWF, Folsom, PBSP, RJD, and VSPW. Medications were prescribed HS at CSATF and KVSP, and psychiatrists at CMC were no longer limited in writing HS medication orders. SCC reported compliance with HS medication standards, but did not present any audits.

[396] CRC, Folsom, SQ, and WSP delivered HS medications without adherence to the 8:00 p.m. time requirement. Delivery of HS medications was problematic at CSP/Sac, CSP/Solano, DVI, and PVSP.

Parole Medications

Compliance with standards for providing medications to inmates paroling from institutions was achieved at CIM, CIW, CMC, CSATF, CCWF, DVI, Folsom, RJD, SCC, and VSPW. Institutions that did not meet these standards included CSP/Solano, ISP, PBSP, and SQ. CSP/Corcoran, SVSP, and WSP did not provide audits of parole medications.

Sexual Misconduct:

Generally, compliance with protocols regulating mental health assessments for use in the discipline of sexual misconduct violations remained mixed during the monitoring period.

In its six reported cases, ASP completed all required screenings, with five comprehensive evaluations completed and one diagnosis of Exhibitionism. CIW, HDSP, and MCSP were compliant with required protocols, and NKSP remained partially compliant.

At VSPW, required screenings were conducted, but seven of eight were untimely. None of these evaluations resulted in findings that the behavior was attributable to Exhibitionism, but the scope of these examinations was inadequate to support such findings. WSP completed all required screenings, which were all reviewed by IDTTs. However, screenings were sometimes days late due to custody delays in forwarding documentation. CCI also completed required screenings, although they were often delayed. Quality of the screenings, treatment plans, and evaluations varied by provider. At SVSP, screenings included a full mental health evaluation but occurred one to two weeks after the violation. Two inmates were referred

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[399] Significant differences in the clinical indecent exposure protocols between the PBSP *Freitag* model and the CDCR systemwide model negatively affected both programs. The PBSP *Freitag* program clinically treated only inmates who consented to treatment. The designation of these inmates at the EOP level of care, regardless of their history or psychiatric diagnoses, resulted in disruptive behavior and adversely affected the therapeutic milieu in the PSU. The placement of these inmates in the same pod tended to reinforce and "normalize" their deviant behavior.

Transfers:

Non-Desert Men's Institutions

At every point along the continuum of care for caseload inmates, lack of timely access to appropriate levels of care remained a significant challenge for the MHSDS. Inmates waiting for acute and intermediate inpatient care beds at DMH and for EOP beds occupied MHCBs. At the same time, inmates awaiting care in those MHCBs filled growing numbers of MHOHU beds and makeshift holding areas, while inmates in need of care languished in reception centers and administrative segregation. The result of this logjam was a population of seriously mentally ill inmates held for too long in the wrong treatment settings, or cycling in and out of acute crisis, or spending increasing amounts of time in administrative segregation units.

DMH acute care resources for male inmates were insufficient. They consisted of 130 beds at CMF and 25 beds at ASH. Increasing numbers of rescinded referrals translated to delayed access and a waiting list that sometimes exceeded 60 inmates during the monitoring period. Of the 18 prisons that referred inmates to the acute care programs at CMF and ASH, 16 reported delayed access. Most of these cases and the longest delays were associated with referrals of non-suicidal acutely psychotic inmates. Such referrals, considered low priority, were routinely placed on a waiting list and were commonly rescinded by the institution. Referred [400] inmates within 30 days of parole and inmates without parole dates continued to be rejected for care by DMH. Consequently, a large number of referrals—more than 25 percent of referrals at nine prisons—failed to result in transfers. The portion of acute care referrals resulting in transfers was less than 40 percent at CIM, CMC, HDSP, and CSP/Solano; 50 percent at SQ; and barely 60 percent at RJD. Despite such slow access and declining success rates, many institutions continued to generate a reasonable number of acute care referrals. CIM, CMC, and PBSP produced more than 50 referrals to acute care during the monitoring period, followed by CSP/Sac with 45 referrals, MCSP with 31 referrals, and KVSP with 24 referrals. CCI, CSP/Corcoran, CSATF, HDSP, NKSP, and SQ generated between 11 and 20 referrals, while CSP/Solano, CSP/LAC, RJD, and SVSP produced fewer than ten referrals. With their large and complex mental health programs, CSP/LAC, RJD, and SVSP all underutilized DMH acute care resources.

CMF continued to use 20 beds within DMH's APP at the CMF facility as MHCBs. While this arrangement provided access to these MHCB—like beds, it blocked access to DMH acute care for most CMF inmates in need of such care. CMF inmates who required acute services after spending time in the MHCB wing rarely moved from it to the three acute care wings of the hospital where they would have had access to needed higher level acute care programs and services.

Sixteen institutions referred inmates to DMH intermediate care programs during the monitoring period. There were excessively long transfer delays that resulted from SVPP's intermediate care waiting list, which swelled to over 170 inmates in July 2008. As a result, increasing numbers of Level IV inmates were denied access to intermediate care. Institutional records, albeit incomplete and unclear in some instances, indicated that only slightly more than a [401] third of SVPP referrals resulted in transfers. A growing number of institutions, including CSP/Sac, CSATF, MCSP, SVSP, and WSP, underutilized intermediate care resources. This troubling trend appeared to be related to frustration and perceived futility of referrals on the part of mental health clinicians.

Transfers to ASH generally occurred within 30 days of referral, although only a few prisons transferred inmates to ASH during the reporting period. CMC and RJD generated over 90 percent of all ASH referrals, with 21 and 36, respectively.

CMF and DMH generated nearly all referrals to the intermediate care programs at CMF. Access to intermediate care and the day treatment programs was reportedly good for CMF inmates who had relatively lower security scores and uncomplicated case factors. RJD, the only other prison reported to have made referrals to intermediate care at CMF, transferred five inmates. The average delay between referral and transfer for these inmates was 38 days.

The scarcity of MHCBs for CDCR's male inmate population continued. The problem was exacerbated by the filling of MHCBs with decompensated and fragile inmates who were waiting for weeks to months for transfers to appropriate higher levels of care. At CSP/LAC, use of MHCBs for inmates with chronic, long-term medical conditions regularly reduced by nearly half the institution's MHCB capacity, although this particular problem was no longer pervasive throughout the state. When necessary, medical patients were moved to community hospital beds in order to open beds in CTCs for mental health admissions at CSP/Corcoran, CSATF, PVSP, and RJD.

Only six prisons, CMF, CSP/Corcoran, CSATF, HDSP, PBSP, and PVSP, reported adequate and timely access to licensed MHCBs. The remaining prisons used OHUs, MHOHUs, and a variety of temporary holding areas to monitor inmates for whom

MHCBs were [402] unavailable. Data provided by the health care placement oversight program (HCPOP), a department within the DCHCS tasked with finding available MHCBs for inmates throughout the state, highlighted the growing crisis. During the final quarter of 2007, HCPOP received a monthly average of 181 referrals, 27 percent of which resulted in MHCB placement. In contrast, during the second quarter of 2008, HCPOP received a monthly average of 314 referrals, of which 15 percent resulted in placement in an MHCB.

Fourteen prisons had licensed crisis care units, nine of which were too small to accommodate the local inmate population. Despite having 26 CTC beds, CSP/Sac relied on 20 MHOHU beds and 15 holding areas to monitor inmates for whom MHCBs were unavailable. The MHOHU absorbed an average of 157 placements a month, nearly half of which lasted longer than 72 hours. Holding areas were used an average of 29 times per month, with stays exceeding 24 hours for a quarter of all placements. MCSP used six MHOHU beds and five observation cells to monitor inmates when its eight-bed MHCB unit was full. On a monthly basis, the MHOHU received an average of 45 placements, a quarter to a third of which lasted longer than 72 hours.

Utilization of the observation cells at MCSP was not accurately tracked. CSP/LAC, CSP/Solano, KVSP, NKSP, RJD, SVSP, and WSP, all with licensed CTCs, routinely used holding cells and tanks to monitor inmates for whom MHCBs were unavailable. Utilization of these cells was not adequately tracked at CSP/Solano, KVSP, RJD, and SVSP.

Eight prisons did not have licensed MHCBs and relied on other prisons for crisis care. Folsom transferred inmates in need of crisis care to CSP/Sac, but although such transfers were immediate, 68 percent of these referrals were placed in MHOHUs because MHCBs were unavailable at CSP/Sac. ASP, CCI, CRC, CTF, DVI, SCC, and SQ used unlicensed OHUs to [403] monitor inmates in crisis and to assess the need for transfer to an MHCB unit. The average number of OHU placements per month was less than 22 at CRC, SCC, and CTF. The number of placements ranged from 31 to 38 at CCI and ASP, was 63 at SQ, and reached 91 at DVI. ASP, CCI, and DVI used alternative sites to monitor inmates for whom OHU beds were unavailable.

Slow access to crisis beds resulted in long OHU admissions and a large number of rescinded MHCB referrals. OHU length of stay at CCI, CTF, DVI, SCC, and SQ routinely exceeded 72 hours, and less than half of the MHCB referrals at ASP, CCI, and DVI resulted in transfer. SCC and SQ rescinded 35 and 36 percent, respectively, of MHCB referrals. Transfers to MHCB units almost never occurred within 24 hours of referral, and delays of two weeks were common. Notably, CTF did not track MHCB transfers.

In light of the statewide shortage of licensed crisis care beds, CIM and CMC were permitted by the court to temporarily utilize unlicensed infirmary beds as MHCBs. At CIM, a 30-bed infirmary received an average of 146 admissions per month. Holding areas in housing units were used to monitor inmates for whom infirmary beds were unavailable. About ten percent of such placements, of which there were 28 in March 2008 and 48 in April 2008, exceeded 72 hours.

Nearly all inmates at the EOP level of care were transferred timely from the mainline programs at CRC, Folsom, and SCC, followed closely by ASP with

85 percent of EOP transfers meeting the 60-day timeframe. However, about a third of the EOP inmates transferred from the mainline programs at CSP/Solano, CSATF, and PVSP waited longer than 60 days. CTF and KVSP did not adequately track EOP transfers.

None of the Department's reception centers consistently transferred EOP inmates within 60 days. The compliance rate for meeting the 60-day timeframe ranged from a low of [404] about 44 percent at CCI to a high of 68 percent at DVI, with an average of 56 percent among nine reception centers. Excessive waits of many months were common, and protocols for expedited, 30-day transfers were underutilized. Transfer delays were often the result of the lack of EOP beds, particularly in Level IV SNY programs. However, endorsement delays associated with untimely completion of medical clearance Chronos, RVR protocols, and sluggish classification processes were increasingly common.

Only Folsom routinely transferred inmates to EOP administrative segregation hubs in a timely manner. CIM, MCSP, PVSP, SCC, and WSP often failed to meet the 30-day transfer timeframe, and waits in excess of 90 days were increasingly common.

PBSP and CSP/Sac reported timely access to PSU beds, in large part due to their advantage of having PSU programs. SVSP reported slow access during the first quarter of 2008, but managed to transfer all inmates within one month of PSU endorsement during the second quarter of 2008. CMF, CSP/Corcoran, CSP/LAC, MCSP, SVSP, and WSP failed to consistently meet the 60-day timeframe for PSU transfers, often missing the mark by several weeks.

Only CIM, CSP/LAC, NKSP, RJD, and SQ reliably provided data on lengths of stay for 3CMS inmates in their reception centers. The compliance rate for meeting the 90-day timeframe ranged from a low of 52 percent at SQ to a high of 80 percent at NKSP. For 3CMS inmates transferred from CIM during the monitoring period, the average length of stay was 98 days.

Desert Institutions

Calipatria, CCC, Centinela, CVSP, and ISP did not have MHSDS programs due to their desert locations. The average daily MHSDS census at these prisons ranged from near zero at CCC to approximately 40 inmates at Calipatria. Most of these inmates were placed in the

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[407] MHCB unit at CCWF. Nearly all of these inmates were held in safety and/or observation cells for more than a week before being referred to an MHCB.

All EOP inmates transferred from CCWF, and 91 percent of EOP inmates transferred from VSPW waited less than 60 days. The reception center at CIW processed 76 EOP transfers, a quarter of which exceeded the 60-day timeframe. The delayed transfers were attributed to internal problems, including missing chronos, pending RVRs, and backlogged record audits. Nearly all 3CMS transfers occurred within 90 days.

Access to the ten-bed PSU at CIW appeared adequate. During the first six months of 2008, CIW transferred two inmates to the PSU, both of whom were placed within five days of endorsement.

Referrals:

Timely institutional response to routine referrals within five work days continued to elude most institutions. A number of institutions failed to consistently respond to routine referrals of inmates for mental health services within the five day timeframe. At CCI, CMC, CSP/Corcoran, CSP/Solano, CSATF, DVI, KVSP, MCSP, RJD, and SCC, there were a substantial number of routine referrals that were not processed timely, with compliance rates ranging from 17 percent to 70 percent, and average response times ranging from 6.4 to 23 days. HDSP, PBSP, PVSP, and SQ improved, with average response times that approached five days and compliance rates above 80 percent. CMF consistently responded to routine mental health referrals within five working days. Only a handful of prisons tracked response times for urgent and emergent mental health referrals. CCI, CMC, CTF, KVSP, and SVSP were unable to consistently respond to urgent and/or emergent referrals within prescribed timeframes. ASP, [408] CSP/Solano, Folsom, and PVSP, on the other hand, responded timely to urgent and/or emergent referrals.

CONCLUSION

The twenty-first monitoring period found the CDCR in the midst of changing conditions that, in all probability, will affect it for years to come. Trial in the prison overcrowding litigation took place. The State of California reported major budget deficits. State officials announced possible fiscal actions that, if implemented, may deter CDCR's current operations as well as its long-term planning and development, particularly in the area of facility construction. As of this writing, the prospect of some limited relief from these budgetary strains is beginning to manifest itself, but their long-term effects are far from clear.

Overall, the staffing of mental health clinical positions continued to improve during the monitoring period, with a decline in the vacancy rate from 28 percent to 19 percent since the preceding monitoring period. Use of registry staff lowered the functional vacancy rate for these positions from 17 percent to 11 percent.

There were improvements across the board with filling supervisory psychiatry positions. For chief psychiatrist positions, the vacancy rate fell from 42 percent to 16 percent, and for senior psychologist positions, it dropped, albeit not as dramatically, from 47 percent to 38 percent. Adequate full-time staffing of line psychiatry positions continued to elude the Department, with its vacancy rate of 33 percent, which, while still too high, was an improvement over the rate of 51 percent in the preceding monitoring period. Use of contractors helped greatly with covering these core mental health positions and lowered the functional vacancy rate to six percent. Commendably, the Department managed to fill all of its allocated chief psychologist positions, and maintained its vacancy rate of 13 percent for senior psychologist positions. For [409] line psychologists, the vacancy rate declined from 27 percent to 18 percent, and was reduced functionally to six percent with use of contractors. The vacancy rate and functional vacancy rate for social work positions stood at 11 percent and five percent, respectively. Unfortunately for both psych tech and recreation therapist positions, their respective vacancy rates of 19 percent and 23 percent were unimproved, with very sparse use of contractors.

These developments in mental health staffing indicate a continuation of the generally positive trend that was seen in the twentieth monitoring period. More work is needed to bring vacancy rates among staff psychiatrists, psych techs, and recreation therapists into line with the other better staffed mental health positions.

While the Department's improvements in mental health staffing advanced its position on the continuum of its access-to-care service model, already-scarce mental health treatment space in a number of institutions was even further strained. Only major construction can remediate this problem, given its scale.

An increasing number of institutions met or maintained quality management activity standards, but others lagged behind in this area. Several institutions' programs consisted primarily of UHR audits or reviews and/or not using quality management procedures to address issues with delivery of care. The most serious problems in this area were found at desert institutions. Local governing bodies, which are required at all institutions that have licensed mental health inpatient units, did not consistently meet, keep appropriate minutes, or secure attendance by required participants. Quality management committees generally did much better, with regular meetings, adequate minutes, and good attendance. Mental health subcommittee function improved during the monitoring period, with regular meetings at 23 of the 33 institutions, and adequate attendance and minutes. Substantive mental health issues were [410] addressed at many institutions. Multiple institutions chartered and utilized QITs effectively. However, lingering shortcomings with audit tools, methodologies, and reporting of results persisted at some institutions. This problem is currently under review and revision by a work group organized within the *Coleman/Plata* coordination effort, and will be examined in the field during the twenty-second monitoring period. A number of institutions still had not instituted meaningful peer review processes for psychiatrists, psychologists, and social workers. The monitor will be looking for a shift toward using qualitative rather than quantitative criteria for all three disciplines by the next monitoring period.

In the area of suicide prevention, only one third of institutional SPCs satisfied Program Guide standards for regular meetings, appropriate attendance, and relevant agendas. Similar problems appeared with institutional ERRCs, which were fully implemented and functional at only a small number of institutions. CPR training of custody staff and conduct of monthly medical emergency response drills in administrative segregation showed improvement generally. However, neither five-day follow-up of inmates discharged from MHCBs or from DMH nor required custody observations were occurring consistently across institutions. This problem is all too similar to a problem that was the subject of a recommendation in Part A of the Special Master's Twentieth Monitoring Report—the lack of follow-through for suicidal inmates who have been released back to general housing from alternative housing areas while pending transfer to an MHCB. Failure to provide five-day follow-up and required custody observation is a "zero tolerance" shortcoming. This is the sort of lapse that can lead to the most serious of consequences in the mental health population. The monitor will be closely examining compliance in the area in the twenty-second monitoring period.

[411] Defendants' plan to reduce suicides in administrative segregation was at least partially implemented at all institutions. Only half of institutions administered pre-placement screens for suicidal behavior prior to admission to administrative segregation, and no institutions included inmate suicide profiles in the process. However, more institutions were complying with the post-placement, 31-question screening process, although a few were conducted in non-confidential settings. One third of designated intake cells had been retrofitted, and accordingly, use of "intake" status placards continued. Two thirds of institutions did custodial 30-minute welfare checks, but most were noncompliant with documentation. Overall, compliance with daily documented psych tech rounds declined, perhaps due to the lingering vacancies in psych tech positions. Daily "check-in" meetings between an administrative segregation sergeant and designated mental health staff were not occurring at nearly 60 percent of institutions. Insufficient out-of-cell exercise time was generally attributable to lack of yard capacity, including walk-alone yards, a number of which were under construction or completed during the monitoring period. Due to infrastructure limitations, most institutions could not offer access to in-cell electrical appliances to nondisciplinary inmates in administrative segregation.

In the area of medication management, there were both significant changes and lingering problems. The Maxor pharmacy management information system was initiated or continued at a number of institutions. Despite some start-up problems, long-term improvements were anticipated. Responsibility for conduct of medication management audits was shifted from mental health to nursing staff. Audit results showed overall improvement with timely provision of medications to inmates following arrival or intra-institutional housing changes. Medication orders were renewed timely at most institutions. Medication administration and length of pill lines remained problematic at many institutions, but expansion of proper use of HS medications. [412] With respect to inmates who were noncompliant with their medication regimes, identification, documentation, referral, and timely response remained generally elusive. With some exceptions, there was generally improvement across institutions with use of appropriate medication informed consent forms, compliance with standards for laboratory testing of psychotropic medications, appropriate use of Keyhea orders, and delivery of parole medications.

Management of inmate sexual misconduct violations continued to challenge the institutions. Institutions experienced problems with not conducting screenings timely or not conducting them at all. Some incidents of sexual misconduct escaped referred to mental health. In some cases, comprehensive evaluations did not occur when indicated, or varied by treatment provider. Documentation in all parts of the process remained problematic. There were very few diagnoses of Exhibitionism, and endorsements and transfers to treatment programs for sexual misconduct at CSP/Corcoran, CSP/Sac, and PBSP were often delayed. CSP/Sac's Exhibitionism program was activated in May 2008. CSP/Corcoran implemented its operational procedure on treatment for Exhibitionism and conducted psychotherapeutic groups for inmates in the program. Due to problems in the screening and diagnosis process, PBSP reported that few inmates referred to its program met treatment criteria. Differences in the clinical indecent exposure protocols between the institution's *Freitag* model and the CDCR protocols affected both programs negatively.

The greatest challenge for mental health services in CDCR continued to be the absence of timely access to appropriate levels of care at every point in the system. The overwhelming majority of referrals to acute care at CMF and ASH were met with delayed access. Admission of referred acutely psychotic non-suicidal inmates was commonly delayed, with longer waiting lists and routine rescissions. Delayed access or lack of it altogether were [413] experienced in transfers to acute and intermediate levels of care at DMH, to EOP beds, and to MHCBs and PSU beds for men. The primary cause of this problem was a systemwide lack of such beds, and the effect, not surprisingly, was the holding of many inmates in unsuitable settings, sometimes for significant periods of time, with repeated placements in administrative segregation and referrals to acute care. As a result, a significant number of the more severely mentally ill inmates experienced extended prison stays, only further exacerbating the already short supply of available mental health resources. However, the long-standing problem of DMH automatic rejection of inmates who would be paroling within 30 days or who did not have parole dates was finally resolved. The monitor will continue to examine DMH rejections for this practice.

Access to inpatient intermediate care at SVPP was effectively denied for increasing numbers of Level IV inmates. There was trend toward perceived futility of referral for intermediate care, and consequent under-referral, at CSP/Sac, CSATF, MCSP, SVSP, and WSP. Although inmates who were accepted at ASH were routinely transferred within 30 days, only CMC and

RJD accounted for 90 percent of ASH referrals during the monitoring period.

MHCBs for men remained inadequate, with nine of the 14 institutions that have licensed crisis care units unable to meet local bed needs. Data showed that in 2007, DCHCS placed 27 percent of referred inmates into MHCBs, while during the second quarter of 2008, 15 percent of referred inmates were actually placed in MHCBs. Only CMF, CSP/Corcoran, CSATF, HDSP, PBSP, and PVSP reported appropriate access. Problems with access for men were significantly exacerbated by delayed access to acute and intermediate care and to EOP programs. There was a backup in MHCBs where many severely mentally ill inmates waited for even months for higher levels of care while referrals to MHCBs were rescinded. Another [414] untoward effect was over-reliance on OHUs, MHOHUs, and an assortment of temporary areas to hold inmates when MHCBs were not available. Stays in OHUs were excessively long, and were often not adequately tracked.

Compliance with transfers to EOP programs was mixed. A small number of non-reception center institutions transferred inmates to EOP programs in a timely manner, but none of the reception centers consistently transferred EOP inmates within *Coleman* Program Guide timeframes. Expedited transfers for EOP inmates were significantly under-utilized. Only Folsom routinely transferred inmates to an EOP administrative segregation hub in a timely manner. EOP transfer delays were tied to issues with bed capacity, particularly for Level IV SNY inmates.

Transfers to PSUs were reported timely at PBSP and CSP/Sac, which both have PSUs, but other institutions reported consistent delays, often exceeding timelines by several weeks.

For women inmates, access to higher levels of care presented a mixed picture. Problems at the DMH level tended to result from restrictive institutional referral practices and delays rather than limitations on capacity. CCWF referred the most women to Patton State Hospital, while VSPW seldom utilized DMH. Clinicians at CIW reported discouragement with DMH referrals after receiving rejections. At CCWF and CIW, access to these institutions' licensed MHCB beds was adequate. VSPW, however, did not transfer inmates to MHCBs when clinically indicated, nor did it adhere to CDCR policies and procedures regarding OHU use. EOP transfers from CCWF and VSPW were timely for the most part, but CIW reported problems with timely EOP transfers, correlated with missing chronos, pending RVRs, and backlogged records.

Undeniably, the twenty-first monitoring period saw the defendants make progress with their implementation of several court-ordered plans and their continuation of others. Still, [415] their progress was at best mixed and in many respects was disappointing with regard to meeting mental health bed needs on a particularized, project-specific basis, for both the short and the long term. In its recent order dated March 30, 2009, the *Coleman* Court has focused intensely on the defendants' performance in response to all existing court orders for provision of mental health beds for CDCR inmates, and on their strategy for comprehensively meeting inmate mental health bed needs on a long-range basis. This order established a number of near-term deadlines for compliance with outstanding orders concerning construction of mental health beds. For the 50- bed MHCB at CMC, among other things, defendants were ordered to take all steps necessary by April 23, 2009, to have procured necessary executed contracts for construction, and provide a detailed schedule including a date certain for completion of this project. For the 64-bed ICF at SVSP, among other things, the defendants were ordered to submit by April 29, 2009, a detailed schedule for completion, opening, and filling of those beds, and a date certain by which the unit shall be open for occupancy. The court also ordered that by May 26, 2009, defendants must file detailed activation schedules for completion of all other court-ordered construction projects, and develop and file concrete proposals to meet the remaining short-term, intermediate, and long-range bed needs of the *Coleman* plaintiff class. In addition, the Court ordered CDCR and DMH clinicians to work together to conduct a modified assessment to identify any members of the plaintiff class who have unmet needs for DMH inpatient care, and to assess and refer these inmates for such care on an expedited basis.

In short, the Court's order calls for an accelerated response from the defendants to meet existing bed needs and identify any heretofore undetected needs for DMH-level inpatient care. With its intensified timetable and comprehensive scope, this order holds great promise for the most rapid and far-reaching advancement in the provision of mental health services to CDCR [416] inmates since the *Coleman* case entered its compliance phase 14 years ago. The importance of defendants' compliance with their obligations under this order cannot be overstated. If their charge is executed properly, it may well set the course for a meaningful and lasting solution to the unmet mental health needs in the CDCR inmate population. Unquestionably, for the near future, the defendants' resources will be absorbed with meeting these specific demands, and they will likely continue to be tapped thereafter as the resulting new mental health beds come on line and are integrated into an effective management strategy. In this context of intense focused effort, the Special Master will refrain from offering recommendations for additional court orders at this time.

Suffice it to say, however, that in addition to fulfilling their duties under the Court's recent mental health bed plan and modified assessment order, the defendants must also allocate their resources during the next several months to maintain the progress they have already made in other areas of mental health programming, and must redouble their efforts in those areas which have yet to satisfy Program Guide benchmarks. As cited in several specific instances within the foregoing Report, during the twenty-second monitoring period, the Special Master will be closely examining those institutions that have fallen short of meeting Program Guide criteria. Particular attention will be given to examining existing psychiatric medication prescribing practices, and to conditions and clinical practices in the OHU and safety cells at VSPW.

This report was sent in draft form to the parties on May 15, 2009. In response, plaintiffs requested that the Special Master make six recommendations, each of which is addressed individually below. At this time, the Special Master is not going to make these recommendations, nor any others. The overriding consideration for now is to enable defendants [417] to focus their resources on compliance with recent orders of the Coleman court concerning assessments and transfers of inmates to higher levels of care, and on meeting short-term, intermediate, and long-range mental health bed needs. Accomplishment of these goals will address most of the concerns raised by the plaintiffs in their proposed recommendations. It is therefore imperative that defendants' efforts not be distracted from this mission.

On March 24, 2009, the court held a hearing on what further steps must be taken to insure timely compliance with existing orders regarding provision of necessary mental health beds to members of the plaintiff class. With specific regard to existing court-ordered projects, it ordered defendants to proceed with contracting to construct the 50-bed MHCB at CMC, to submit a detailed schedule for completion and opening no later than June 15, 2009 of the 64-bed intermediate care facility at SVSP, and to submit detailed activation schedules for all other court-ordered construction projects. The court also ordered defendants to continue to develop by May 26, 2009 concrete proposals for meeting the remaining short-term, intermediate, and long-range bed needs of the plaintiff class. In addition, the court ordered both CDCR's and DMH's clinicians to conduct a modified needs assessment to detect and refer for appropriate inpatient mental health care any inmates who have unmet needs such care.

The court held another hearing on June 16, 2009. Among the matters taken up by the court at that time was the defendants' schedule for activation of previously court-ordered construction projects, defendants' short-term and intermediate plans for meeting mental health bed needs, and defendants' long-range bed plan. For the 13 previously court-ordered projects, the court approved the schedules proposed by the defendants and ordered them to report monthly to the Special Master on actions taken and whether each of the projects remains on schedule.

* * *

[424] treatment based on their parole status. Plaintiffs point to the two institutions—HDSP and WSP—at which inmates' parole status was cited as an impediment to inpatient care at the time of the monitor's visits during the twenty first round. This issue has already been addressed in substance, as an order was entered on August 8, 2008, barring consideration of inmates' parole status as grounds for denial inpatient care. The monitor's twenty first review of these two institutions occurred on October 14-16, 2008 and September 16-18, 2008, respectively. It is reasonable to infer that although these visits followed the entry of the order, staff were not yet aware of the ban and had not yet incorporated it into their practices. This report shall serve as notice to these two institutions that, if they have not already modified their practices to comply with the August 8, 2008 order, they must do so forthwith. With that said, the plaintiffs' request for training in this area does not at this time rise to the level of meriting a court order for staff training on the substance of the August 8, 2008 order.

This Report will close on a positive note, citing three institutions that demonstrated sufficient improvement with their levels of compliance with *Coleman* Program Guide standards and court orders while managing to maintain their performance. The Special Master recommends that, based on SCC's record of performance, it be added to the list of those institutions monitored by paper review. He further recommends that on-site monitoring at CIW and CMC be reduced to one-day visits at each of these institutions for examination of their levels of compliance in their PSUs, CTCs, adherence to heat plan measures, and possibly with regard to broader issues as well. Paper review of CMC will include tracking of the construction of the 50- bed MHCB unit there, and paper review of CIW will include patient access to Patton State Hospital and construction of the ICF PSU there.

[425] Respectfully submitted,

/s/ Matthew A. Lopes, Jr., Esq.
Special Master

July 31, 2009

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. 2:-90-cv-0520-LKK-JFM (PC)

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

This matter is before the court on the Special Master's Report and Recommendations on His Expert's Report on Suicides Completed in the California Department of Corrections and Rehabilitation in Calendar Year 2007 filed December 24, 2009 (hereafter December 24, 2009 Report and Recommendations). Therein, the special master recommends orders based on recommendations contained in the Report on Suicides Completed In the California Department of Corrections and Rehabilitation in Calendar Year 2007, filed September 17, 2009, (hereafter the 2007 Suicide Report). Defendants interpose several objections to the special master's report and recommendations. Plaintiffs have filed an opposition to defendants' objections, and defendants have filed a reply in support thereof.

The special master recommends the following orders:

> [2] 1. Defendants shall specifically identify inmates' known and/or suspected medical problems and medications within these inmates' mental health treatment plans, rather than merely allude to them by reference to other records.
>
> 2. CDCR and DMH shall communicate and collaborate with each other to ensure that the highest level of care provided by DMH to CDCR inmates is given to any inmate who has been determined to need it.
>
> 3. Defendants shall accord priority to access to inpatient care for CDCR inmates at DMH facilities, particularly for Level III and Level IV inmates. This involves requiring clinical staff to properly assess suicide risk factors for inmates experiencing changes in mental health functioning, particularly on placement in administrative segregation or other single-cell housing. A vital component of this process is appropriate crisis-level service in treatment settings such as MHCBs, or limited treatment within OHUs, until transfers to DMH facilities can be achieved. DMH must be held accountable for its decisions on admissions or rejections and cannot be permitted to avoid transparency behind a pretext of patient "confidentiality."
>
> 4. Defendants shall fully and timely implement the suicide prevention and review processes that are already in place, at both the institutional and department levels, and shall give this priority. This includes incorporation of revised policy and

> procedural guidelines and court orders into these processes. It also entails the identification of deficiencies at the facility and systemic levels, appropriate follow-up of corrective action plans, and submission of documentation to the *Coleman* special master on the outcomes of investigations of staff misconduct, negligence, and error. This process must include not only training but supervision and appropriate supervisory action regarding staff performance.

December 24, 2009 Report and Recommendations at 2. The recommended orders are based on several findings in the 2007 Suicide Report, including:

- The CDCR inmate suicide rate in 2007 continued "CDCR's pattern of exceeding the national prison suicide rate."
- The 2007 CDCR inmate suicide rate was "higher by 1.5 percent than the CDCR average annual suicide rate per 100,000 inmates for the preceding nine years."
- "In 82 percent of the suicide cases in 2007, there was at least some degree of inadequacy in assessment, treatment, or intervention, for the highest rate of inadequacy in these areas in the past several years."
- [3] In 79 percent of cases, deadlines in completion and submission of required documentation of suicides were missed, and some reporting was not completed at all by the time the 2007 Suicide Report was filed.
- Although three suicides were completed in Department of Mental Health (DMH) facilities, DMH refused to provide complete docu-

> mentation of quality improvement and other action plans to the special master.

2007 Suicide Report at 1-2.

At the outset, the court notes that the recommended orders are almost identical to the four recommendations contained in the 2007 Suicide Report, which was filed on September 17, 2009. *Id.* at 18-19. On October 1, 2009, defendants filed a motion to modify that report. Defendants did not object to the substance of any of the recommendations. Defendants did, however, object to the request by plaintiffs, made in opposition to the motion, that those recommendations be made orders of this court; defendants contended then only that none of the recommendations meets the criteria for injunctive relief set forth in 18 U.S.C. § 3626. *See* Defendants' Reply Brief, filed November 6, 2009, at 11. By order filed November 23, 2009, defendants' motion was denied. Plaintiffs' request that the recommendations in the 2007 Suicide Report be made orders of this court was also denied, without prejudice, based on the court's determination that requests for such orders should come, if at all, from the special master. Order filed November 23, 2009, at 14. On December 24, 2009, the special master filed the instant request. Defendants now raise again their objection that the recommended orders do not meet the criteria for injunctive relief set forth in 18 U.S.C. § 3626, and they raise additional objections to adoption of some of the recommendations as orders of the court.

Suicide prevention and policy has been monitored by the *Coleman* special master since late 1998, *see* Order filed Dec. 22, 2000, at 1 n.1, and the special master has filed annual reports on completed inmate suicides in the California Department of Corrections and Rehabilitation (CDCR) since October 2000. The first Suicide Report, filed on October 10, 2000 as part of the Sixth Monitoring Report, examined "completed suicides in the California [4] Department of Corrections (CDC) from October 1998 through December 1999" and included several observations and recommendations. *Coleman* Suicide Report, October 6, 2000, appended to Sixth Monitoring Report, at 1, 5-6. All of the observations and recommendations in that report were adopted by this court in an order filed December 22, 2000. *See* Order filed December 22, 2000, at 4.

Since the first report, the special master's experts have conducted annual reviews of completed inmate suicides, and their reports have been filed with the court either as part of the special master's monitoring reports or as separate stand alone reports. The 2007 Suicide Report is the most recent of these reports. In addition, the special master has filed several other reports and recommendations related to suicide prevention and policy. Many of the recommendations contained in these reports have become orders of this court.

The issues undergirding the recommendations before the court have been the subject of recommendations from the special master several times over the past decade. For instance, the need for adequate consideration of information available in the medical records of *Coleman* class members has been the subject of numerous observations and recommendations in Suicide Reports filed by the special master. In the 2004 Suicide Report, filed May 9, 2006, the special master's expert observed that "[t]he failure of clinicians to make use of available information to ensure that inmates are fully and appropriately screened, assessed and treated remained a dominant problem. In too many cases, completed suicides occurred when information in a UHR [Unit Health Record] or central file, had it been reviewed by mental health clinicians during interviews with inmates, might have alerted mental health staff to inmates' potential for suicide." 2004 Suicide Report at 10. Similar observations were made in the 2005 and 2006 Suicide Reports. *See* 2005 Suicide Report, filed November 26, 2007, at 12; 2006 Suicide Report, filed September 12, 2008, at 10. On July 31, 2007, the special master filed a report prepared by his psychiatric experts summarizing their review of completed suicides by CDCR inmates from 1999 through 2004. That report also identifies the failure of clinicians to [5] "review fully and carefully available documentation, such as health and classification records, for indices of prior suicidal activity or ideation" among "clinical practices . . . that ought to be addressed." Special Master's Psychiatric Experts' Review of Completed Suicides in the California Department of Corrections and Rehabilitation in Calendar Years 1999 through 2004, filed July 31, 2007 (hereafter Six-Year Suicide Report), at 9.

The need for effective communication and collaboration between CDCR and DMH to provide *Coleman* class members with access to necessary levels of DMH care has also been the subject of repeated observations and recommendations by the special master. Similarly, defendants' obligation to provide "timely access to DMH inpatient placements, particularly for Level III and Level IV inmates," 2004 Suicide Report at 11, has been the subject of numerous recommendations by the special master and his experts. In the Six-Year Suicide Report, the special master's experts observed that three suicides in DMH facilities in 2001 revealed "the need for better coordination and cooperation in the responses of both agencies." Six-Year Suicide Report at 7. The Six-Year Suicide Report highlighted, inter alia, "[t]he failure of clinical staff to refer potentially suicidal prisoners to programs with more intensive monitoring and care" and "[t]he provision of prompt and adequate access to higher levels of monitoring and care to prisoners identified as potentially suicidal" among the items to be addressed by defendants. *Id.* at 9. In the 2003 Suicide Report the special master's expert reported that "74.2 percent of suicides completed in 2003 involved some measure of inadequate treatment or intervention" including "lapses in communication and inattention to documented concerns about the need for an assessment or placement in higher level of care of individuals demonstrating significant mental illness or past suicidal behavior." 2003 Suicide Report, filed April 28, 2005, at 7. In the 2005 Suicide Report, the special master's expert noted the need to repeat and to implement the recommendation that there is a "need for clinicians to monitor suicidal inmates more closely and, where appropriate, aggressively refer decompensating suicidal inmates, especially those at Level [6] III and IV custody levels, to DMH programs." 2005 Suicide Report at 14. A similar recommendation was made in the 2006 Suicide Report. *See* 2006 Suicide Report at 12-13.

Finally, since 2001, when defendants were ordered to implement their Suicide Reporting and Review Policy, the special master's experts have repeatedly identified the need for full implementation of these policies and for timely production of documents necessary to review completed suicides. *See* 2000 Suicide Report at 7; 2003 Suicide Report at 10-11; 2004 Suicide Report at 11; Six-Year Suicide Report at

9; 2005 Suicide Report at 13-14; 2006 Suicide Report at 12.

Most of the foregoing matters have also been the subject of orders of this court. The second and third recommendations are focused at the ongoing struggle to provide *Coleman* class members with access to necessary levels of mental health care, particularly inpatient care. All inpatient mental health care for *Coleman* class members is provided in DMH facilities, either at state mental hospitals or in units operated by DMH at several California prisons. The shortage of available inpatient beds, particularly for Level IV inmates, is extant in this record and has been the subject of numerous court orders to date. In addition, several orders have directed defendants to provide the special master's experts with documents related to the suicide review process. *See* Order filed June 13, 2002 at 2-3; Order filed January. 12, 2004 at 3; Order filed June 10, 2005 at 2.[1]

The increase in both the inmate suicide rate and the percentage of suicide cases with "at least some degree of inadequacy in assessment, treatment, or intervention" is deeply troubling. The fundamental task at hand is for defendants is to take all steps necessary to reduce [7] both the inmate suicide rate and the inadequacies in assessment, treatment and intervention found in an unacceptably high percentage of completed suicides. As noted above, most of the issues for which orders are presently requested by the special master have been the subject of repeated recommendations by the special master, and some are already the subject of existing court orders, yet both the suicide rate and the percentage of suicides with some degree of inadequacy in assessment, treatment or intervention are rising. Before this court enters any further orders directed at the problems of inmate suicides, both the CDCR defendants and the DMH defendants will be directed to work with the special master to review all suicide prevention and review policies, as well as any other relevant policies and practices, and the implementation of such policies at all institutions, and to identify any modifications to such policies and practices or implementation thereof that may be necessary to address the problem of inmate suicides.

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[1] Defendants object on several grounds that DMH should not be bound by the order filed June 10, 2005. Defendants have not adequately briefed the question of whether a subsequently joined party is bound by existing court orders following such joinder. Nonetheless, the court will direct the DMH defendants to meet and confer with the special master concerning production of information essential to the special master's suicide review process and to develop, if necessary, appropriate policies and procedures for such production. This shall take place within the one hundred and twenty day review period set by this order.

In accordance with the above, IT IS HEREBY ORDERED that:

1. The special master's December 24, 2009 recommendations are not adopted at this time;

2. Over the next one hundred and twenty days, under the guidance of the special master, defendants shall review all suicide prevention policies and practices, all suicide review and reporting processes, and the implementation of such policies, practices and processes. As part of this review, defendants shall identify any and all specific modifications to their suicide prevention policies and practices, their suicide review and reporting processes, and the implementation thereof as may be required to

address the problem of inmate suicides. Within forty-five days thereafter the special master shall report to the court on the foregoing review.

3. DMH defendants shall meet and confer with the special master concerning production of information essential to the special master's suicide review process and shall [8] develop, if necessary, appropriate policies and procedures for such production. This shall take place within the one hundred and twenty day review period set by this order.

DATED: April 14, 2010.

/s/ Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA SACRAMENTO DIVISION

2:90-cv-00520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

DEFENDANTS' RESPONSE TO COURT'S FEBRUARY 12, 2010 ORDER THAT DEFENDANTS FILE AN AMENDED PLAN FOR THE ENHANCED OUTPATIENT PROGRAM POPULATION ORIGINALLY PLANNED FOR THE STARK FACILITY AND RENEW OR WITHDRAW THEIR MOTION FOR RECONSIDERATION AND RELIEF; UPDATE ON STATUS OF LONG-RANGE MENTAL HEALTH BED PLAN

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* * * *

[4] BACKGROUND

On January 4, 2010, the Court ordered that Defendants file an amended plan for their proposed Stark conversion project from a Division of Juvenile Justice facility to an adult male facility. (Docket No. 3761.) This project would house and serve a portion of the adult male Enhanced Outpatient Program (EOP) population consisting of 775 EOP General Population (GP) and 50 EOP Administrative Segregation Unit

(ASU) inmates, for a total of 825 EOP inmates. (Docket No. 3724-2 at 43-45.) The Court ordered that Defendants revise their plan in order to: (1) limit the population for that facility to no more than 137.5% of the facility's design capacity; and (2) meet the concerns identified by the *Coleman* Special Master. (Docket No. 3761 ¶1.c.)

Defendants filed a motion for reconsideration of the Court's January 4, 2010 order requiring them to file an amended plan for the Stark conversion project. (Docket No. 3793.) Concurrent with that filing, Defendants requested that the Court grant them temporary relief from the order so that they could evaluate alternative options to the Stark conversion project, and determine whether a viable alternative option existed. (Docket No. 3792.) By order dated February 12, 2010, the Court granted Defendants ninety days to file an amended bed plan for the Stark conversion project, and ordered that they either renotice their motion for reconsideration and relief or file a notice withdrawing it. (Docket No. 3799 ¶¶ 2-3.)

DEFENDANTS' ALTERNATIVE PROJECT

Defendants have identified a viable alternative project for the Stark EOP population that increases the quality of care provided to the EOP population, and Defendants believe the amended project materially complies with the Court's January 4, 2010 order by addressing the concerns identified in the order. Defendants' amended bed plan for the 825 EOP inmates consists of a combination of: (1) new construction at the Stark facility that will house 525 EOP-GP and 50 EOP-ASU inmates; (2) a reduction in the admissions at Stark by 250 EOP-GP inmates; (3) two new projects at the Substance Abuse Treatment Center (SATF) that will house a combined total of

264 EOP-GP and EOP Sensitive Needs Yard (EOP-SNY) inmates; and (4) the 30 Mental Health Crisis Bed (MHCB) project at the Stark facility. Enclosed as Attachment A, with Exhibits [5] 1-6, is a true and correct copy of Defendants' amended plan with corresponding activation schedules.

Because Defendants' amended plan does not limit the population at the Stark facility to no more than 137.5% of the facility's design capacity, Defendants, concurrent with this filing, renotice their motion for reconsideration and relief from that portion of the Court's January 4, 2010 order that requires Defendants to file an amended plan that limits the population for Stark to no more than 137.5% of the facility's design capacity. In addition, Defendants' amended plan is substantively different from their former plan, and Defendants believe they have addressed the concerns identified in the Court's January 4, 2010 order to provide "either an increase in the amount of out of cell time for class members housed in that program, or reduction in the number of admissions, or some combination of the two." (Docket No. 3761 at 2:15-17.) Accordingly, Defendants are willing to withdraw their motion for reconsideration and relief regarding the portion of the Court's January 4, 2010 order that requires Defendants to file an amended plan that meets the concerns identified by the *Coleman* Special Master. But to the extent Defendants' revised plan does not address those concerns, Defendants also renotice their motion for reconsideration and relief of that portion of the Court's order.

Additionally, Defendants take this opportunity to update the Court on the status of the projects in their long-range mental health bed plan. Enclosed as Attachment B, with Exhibits 1-2, is a true and correct copy of Defendants' update on their long-range mental health bed plan.

Dated: May 13, 2010

Respectfully submitted,

EDMUND G. BROWN JR.
Attorney General of California
JONATHAN L. WOLFF
Senior Assistant Attorney General

/s/ Debbie J. Vorous

DEBBIE J. VOROUS
Deputy Attorney General
Attorneys for Defendants

[Filed 5/13/10]

[1] ATTACHMENT A

[2] STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

ARNOLD SCHWARZENEGGER, GOVERNOR

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May 12, 2010

Ms. Debbie Vorous
Deputy Attorney General
Department of Justice
1300 I Street
Sacramento, CA 94244-2550

Dear Ms. Vorous

Please see enclosed, Defendants' amended long range bed plan and activation schedule for the Heman G. Stark facilities Enhanced Outpatient Programs pursuant to the January 4, 2010 court order in *Coleman v. Schwarzenegger*.

Sincerely,

/s/ Benjamin T. Rice
BENJAMIN T. RICE
General Counsel

Enclosure

[3] FOR SUBMISSION TO THE *COLEMAN* COURT

Long-Range Mental Health Bed Plan

Amended Bed Plan for the 825 Enhanced Outpatient Program Inmates

Originally Planned for the Herman G. Stark Facility

PURPOSE AND BACKGROUND

On November 6, 2009, Defendants submitted a long-range mental health bed plan, including activation schedules. As one of their long-range plans, Defendants proposed to renovate Stark—a former Division of Juvenile Justice Institution—to provide housing, treatment, and office space for 775 Enhanced Outpatient Program – General Population (EOP-GP) and 50 EOP Administrative Segregation Unit (EOP-ASU) inmates, for a total of 825 EOP inmates. On January 4, 2010, the Court declined to approve Defendants' proposal to renovate Stark, and ordered that Defendants file within forty-five days an amended plan that limits the population for that facility to no more than 137.5% of the facility's design capacity and that meets the concerns identified by the *Coleman* Special Master (i.e., reducing the admissions at Stark and/or increasing the amount of out-of-cell time). Defendants requested temporary relief from the Court's order so that they could evaluate alternative options to renovating Stark, and determine whether a viable alternative option existed. On February 12, 2010, the Court granted Defendants an additional ninety days to file an amended plan for the Stark EOP project. This submission, and the activation schedules filed concurrently with it, detail Defendants' amended long-range mental health bed plan to provide housing, treatment, and office space for the 825 EOP inmates originally planned for the Stark facility.[1]

[4] DEFENDANTS' AMENDED BED PLAN

The California Department of Corrections and Rehabilitation (CDCR) assembled a team of individuals to reassess the scope, costs, and schedule for the Stark EOP conversion project, and to identify all viable options to house the 825 EOP inmates planned for that facility. The team was successful—it identified a viable project that increases the quality of care provided to the EOP population, and materially complies with the Court's January 4, 2010 order by addressing the concerns identified by the *Coleman* Special Master. Defendants' amended plan consists of four elements: (1) new construction; (2) a reduction in the admissions at Stark; (3) two new projects at the

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[1] Defendants plan to fund this project via authorization to issue lease-revenue bonds provided by Assembly Bill (AB) 900. Defendants, however, cannot make any representations that the State Legislature will authorize AB 900 lease-revenue financing for this amended plan, the Pooled Money Investment Board will authorize the loans for the interim financing, or that bond counsel will offer an unqualified bond opinion on the validity of the proposed bonds. Additionally, Defendants do not believe that this amended plan satisfies the Prison Litigation Reform Act's requirements that prospective relief be narrowly drawn, extend no further than necessary to correct the alleged violation of the *Coleman* plaintiff class's federal rights, and be the least intrusive means necessary to correct the alleged violation. Among other things, the *Coleman* bed needs identified in the amended plan are based on Navigant Consulting's Spring 2009 population projections. But those projections do not account for population changes that may occur as a result of recent legislative changes, or from the three-judge court's (now stayed) orders requiring the State to reduce the prison population to 137.5% of the prison's combined design capacity within two years.

Substance Abuse Treatment Facility (SATF); and (4) the 30 Mental Health Crisis Bed (MHCB) project at the Stark facility.

First, Defendants propose to build four new housing units on the Northwest corner of the current Stark facility to house the EOP population. Each housing unit is expected to contain 100 cells. Constructing new housing units, rather than renovating the Stark facility as reflected in Defendants' November 6, 2009 filing, will enhance the quality of care for the EOP population in several ways. The cells in the new housing units will be larger than the cells planned for the original Stark project. The new cells will be 80 square feet in size, and Defendants believe that the larger cell size addresses some concerns previously identified about double celling inmates in smaller cells.[2] Additionally, the new units will be built adjacent to existing vocational and programming space, making the space easily accessible to the EOP population.

Defendants expect full occupancy of the four housing units by December 15, 2014. (*See* Ex. 1.) Although Defendants' original activation schedule filed on November 6, 2009 for the Stark conversion project reflected full occupancy by September 15, 2014, the planned completion dates for the amended project have been extended to reflect, in part, the time needed to reevaluate, restart, and document the new project. (Ex. 1.) Given these changes, the amended activation schedule presents the most realistic and reasonable time frame to complete the project.

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[2] Defendants do not admit that the previous size of the cells was inappropriate or unconstitutional.

Nonetheless, CDCR remains committed to identifying ways to accelerate this project, as it has done with other *Coleman* projects. Presently, the Stark project is the only project in Defendants' long-range mental health bed plan with an activation schedule extending into 2014. The other projects' activation schedules reflect completion dates in or before 2013. Moreover, Defendants have demonstrated that they can identify ways to significantly accelerate projects during a project's implementation. For instance, Defendants recently accelerated the scheduled completion date for the 64-bed Intermediate Care Facility (ICF) project at the California Medical Facility (CMF) by nearly one year. (*See* Ex. 2, CMF Activation Schedule.)

Second, Defendants believe that their amended project addresses the concerns identified in the Court's January 4, 2010 order to either reduce the number of admissions or increase out of cell time. Defendants' amended project reduces the overall size of the EOP program at the Stark facility by 250 EOP inmates. The four new housing units will house 525 EOP-GP inmates and 50 EOP-ASU inmates. Half of one of the four housing units will be dedicated to the 50 EOP-ASU inmates.

[5] Third, Defendants propose two new projects to meet the mental health bed needs of 250 EOP inmates that were originally planned for the Stark facility, as reflected in Table 1:

TABLE 1: NEW PROJECTS TO MEET THE EOP POPULATION

SITE	PROJECT DESCRIPTION	CAPACITY
Substance Abuse and Treatment Facility	Dual disorders treatment program for Level I and II EOP-GP inmates with substance use disorders and serious mental illness.	This project was identified in Defendants' November 6, 2009 filing as a short-term project adding 88 EOP-GP beds. Under Defendants' amended plan, this project will be permanent.
Substance Abuse and Treatment Facility	Converted housing for Level I and II EOP Sensitive Needs Yard (SNY) inmates.	This project replaced a project identified in Defendants' November 6, 2009 filing. The modified project adds 176 EOP-SNY beds. Under Defendants' amended plan, this project will be permanent.

The two new SATF projects, which will provide 264 EOP beds, change the total number of EOP beds in Defendants' November 6, 2009 filing from a net capacity of 1,625 beds to 1,639 beds, for an increase of

14 additional beds. This increase of 14 beds is reflected in Table 2:

TABLE 2: CHANGE IN EOP NET CAPACITY

	EOP Bed Numbers in November 6, 2009 Bed Plan	EOP Bed Numbers in May 13, 2010 Amended Stark Proposal	Change in Total EOP Bed Numbers
New Capacity by Institution			
LAC	150	150	0
SVSP	108	108	0
CMF	67	67	0
[6] SATF	0	264	264
Stark	775	525	(250)
Estrella	150	150	0
Dewitt	375	375	0
Total	1,625	1,639	14

(*See* Ex. 3, Men's Long-Range Mental Health Bed Plan, which incorporates this proposed change to the November 6, 2009 long-range mental health bed plan.)

Defendants' amended plan to convert two short-term SATF projects to permanent beds will provide 264 EOP inmates with permanent housing nearly three years sooner than under the Defendants' former plan. CDCR expects to have the 88 EOP-GP dual diagnosis treatment program at SATF fully occupied by June 30, 2010. (Ex. 4.) CDCR has already activated Phase I of the 176 Level I/II EOP-SNY project (conversion of two 44-bed pods) and expects to achieve full occupancy by September 30, 2010. (Ex. 5.)

Fourth, Defendants propose to include the 30 MHCB project at the Stark facility in this plan. Defendants previously sought legislative approval of the scope, cost, and schedule of the 30 MHCB project, but the Joint Legislative Budget Committee (JLBC) did not concur with CDCR's request to proceed with the project. (Ex. 6.) Including the 30 MHCB project into this plan changes how Defendants will present their activation schedules for the court-ordered projects. Defendants will no longer file a separate schedule for the 30 MHCB project; rather, it will be part of the overall "Stark Conversion" project. (*See* Ex. 1.)

[7] ATTACHMENT A

EXHIBIT 1

Project: Stark Conversion[1]
Responsible Person: Chris Meyer/CDCR
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: TDD
Location: Heman G. Stark, Chino, CA
Funding Source: AB 900 (GC 15819.40)

Jay Sturges/DOF
915 L Street, Sacramento California 95814

Report Date: May 12, 2010

Primary Tasks	Duration (Cal Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SR	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost and Schedule for AB 900 30 Day Funding Request Package	272	11/5/09	11/5/09		8/5/10				C. Stevens	Develop Preliminary Program. Conceptual Scope, Schedule and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval	Scope and population revised 03/17/10
Review Funding Request Package	34	8/5/10			9/7/10				C. Lief	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	9/8/10			10/8/10				JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule	1	10/11/10			10/11/10				C. Lief	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule	
Request Loan from PMIA	21	9/28/10			10/18/10				D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	1	10/20/10			10/20/10				Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds	
Architectural/Engineering Contracting	39	10/21/10	11/30/09	N/A	11/29/10				J. Cummings	Select A/E firm. Negotiate Scope and Fee. Execute Contract(s)	Selection of A/E firm started prior to the change in scope of the project.
Preliminary Plans	325	11/30/10			10/21/11				C. Stevens	Criteria/Architectural Programming. Schematic Design, Design Development. Design Review. Develop Initial Group II Equipment List. Update Staffing Requirements. Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	
California Environmental Quality Act Compliance (CEQA)	410	10/21/10	1/4/10	N/A	12/5/11				B. Sleppy	Select Consultant. Negotiate/Execute Contract. Prepare CEQA Documents. Circulate/Comment Period. File Notice of Determination (N.O.D.). Litigation Period	Selection of Consultant started prior to the change in scope of the project
JLBC Approval of Preliminary Plans	45	10/24/11			12/8/11				JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans	
PWB Approval of Preliminary Plans	45	10/25/11			12/9/11				C. Lief	PWB Approval	
Working Drawings (Construction Documents)	295	12/12/11			10/2/12				C. Stevens	Complete Construction Documents. Obtain Regulatory Reviews (SFM, ADA, etc.). Finalize Group II Equipment List. Update Project Schedule and Cost. Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval	
Bid and Award	89	10/3/12			12/31/12				C. Stevens	Advertise for Bids, Hold Pre-Bid Conference. Receive Bids. Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	
Construction	555	1/2/13			7/11/14				C. Stevens & Contractor	Mobilize Construction Contractor, Construction Manager, Inspector of Record. Construct Project. Purchase and Install Group II Equipment. Testing of Systems (Fire alarm, Nurse Call, etc.). Punch List, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval	

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Hire Staff	600	10/19/12			6/11/14				S. Streater K. Baker Warden	Advertise, Hire, and Train Staff	
Activation	60	7/14/14			9/12/14				S. Streater K. Baker Warden	Issue staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment	
Patient Admissions	124	8/13/14			12/15/14				S. Streater K. Baker Warden		

[1] This facility is intended to include 525 EOP, 50 EOP/ASU, 2?64 non-mental health beds, and a 50 (bed) CTC including 30 MHCB

[2] Special Master shall receive updates on construction every 90 days

* * * *

[11] ATTACHMENT A

EXHIBIT 2

Project: 64 Bed Intermediate Care Facility [illegible]
Responsible Person: Deborah Hysen
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: Nacht and Lewis Architects
Location: California Medical Facility, Vacaville (CMF)
Funding Source: AB 900 (GC 15819.40)

Jay Sturges DOF
915 L Street, Sacramento California 95814

Report Date: April 23, 2010

Primary Tasks	Duration (# of Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to Lo	Lead Person	Key Sub-Tasks	Status
PWB Recognition of Project Scope, Cost, and Schedule		[illegible]	[illegible]		[illegible]	[illegible]			C. Lee	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule	
Request Loan from PMIA		[illegible]	[illegible]		[illegible]	[illegible]			D. Berg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	90	[illegible]	[illegible]		[illegible]	[illegible]	38		Director of Finance, State Controller and State Treasurer	Submit Loan application for final design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	Loan request was made on [illegible] and was granted by PMIB on a [illegible] basis. Executive Order [illegible] authorized General Fund loan for Preliminary Plans. On [illegible] PMIB approved the loan for PP funding, and the General Fund loan will be repaid. Design and construction schedule was revised based on [illegible]. There is no impact to overall schedule.
Architecture/Engineering Contracting	3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	30		L. Cummings	Select A/E, RFP, Negotiate Scope and Fee, Execute Contract(s)	Contract execution delayed due to year end work load issues. There is no impact to overall schedule.
Preliminary Plans	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			N. Bealer	Criteria/Architecture Programming, Schematic Design, Design Development, Design Review, [illegible] Equipment List, [illegible] Update Project Cost and Schedule, Prepare JLBC and PWB Submittal Packages.	Preliminary Plans funded in the 2008-[illegible] Budget Act.
California Environmental Quality Act Compliance (CEQA)					[illegible]	[illegible]			[illegible]	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Consider Notice, File Notice of Determination (N.O.D.), Litigation Period	
JLBC Approval of Preliminary Plans	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			JLBC	JLBC Approval. [illegible] provides the JLBC a [illegible] review period before the PWB can approve preliminary plans.	
PWB Approval of Preliminary Plans		[illegible]	[illegible]		[illegible]	[illegible]			C. Lee	PWB Approval	Preliminary Plan approval assures [illegible] with the establishment of scope, cost, and schedule.
Working Drawings (Construction Documents)	[illegible]	[illegible]	[illegible]	18	[illegible]	[illegible]	14		N. Bealer	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for Approval. Submit loan documents to DOF and obtain PMIB approval for loan for the project's cash needs for the next 12 months. [illegible] to PWB for approval.	Contract execution delayed [illegible]. Working drawings are complete. There is no impact to the overall schedule.
Bid and Award	62	[illegible]	[illegible]	21	[illegible]	[illegible]	2		N. Bealer	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	Bid and Award delayed due to [illegible] approval of working drawings. Bids opened on [illegible] and NTP issued [illegible]. There is no impact to the overall schedule.

Primary Tasks	Duration (in Days)	Planned Start	Actual Start	Days Ahead/(Behind)	Planned Complete	Actual Complete	Days Ahead/(Behind)	Complete (certification & [illegible])	Lead Parties	Key Sub-Tasks	Status
Construction	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				[illegible] TBD	[illegible]	[illegible]
Hire Staff	[illegible]	[illegible]			[illegible]				[illegible]	[illegible]	[illegible]
Prepare Plan for Office of Statewide Health Planning and Development (OSHPD) Approval	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				TBD	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]				[illegible]		[illegible]
License Approval	[illegible]	[illegible]			[illegible]				[illegible]	[illegible]	[illegible]
Activation	[illegible]	[illegible]			[illegible]				[illegible]	[illegible]	[illegible]
Patient Admissions	[illegible]	[illegible]			[illegible]				[illegible]	[illegible]	[illegible]

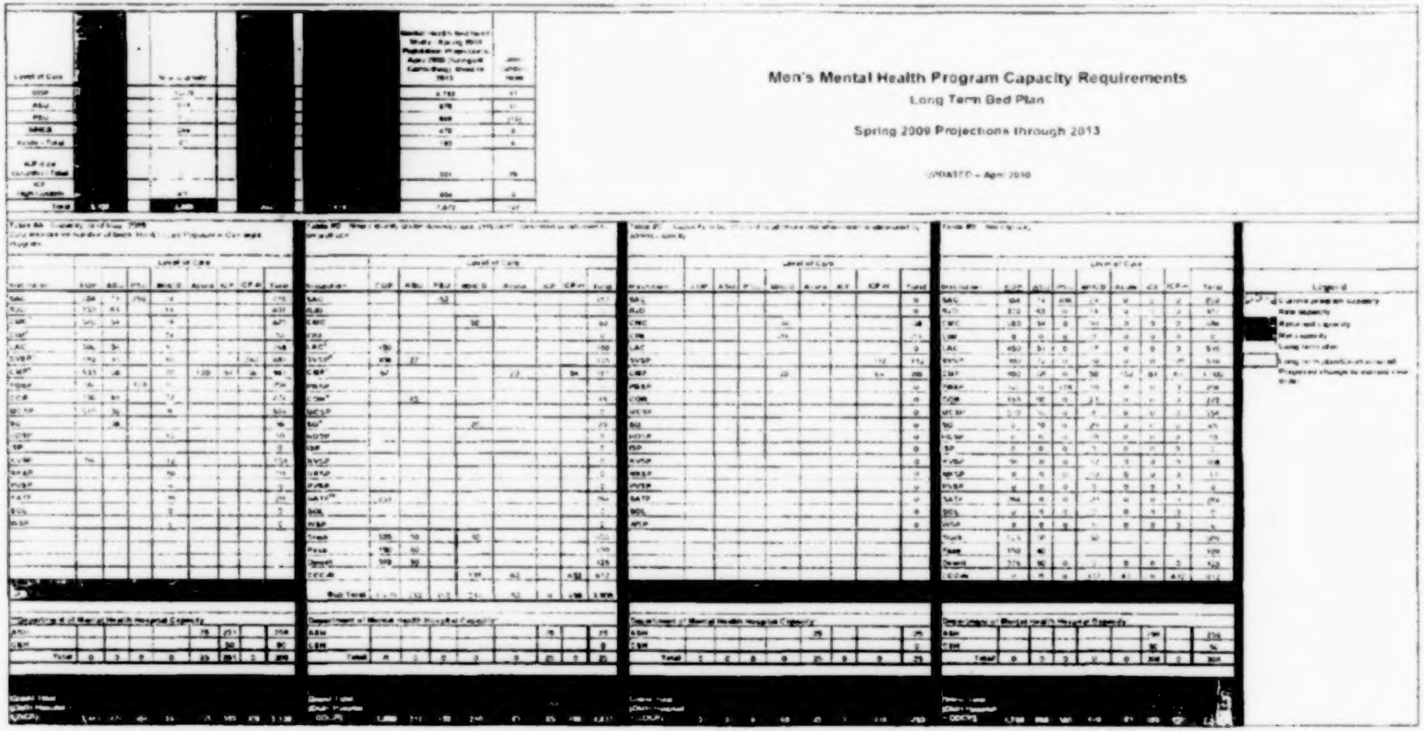
[illegible]

[illegible]

[14] ATTACHMENT A

EXHIBIT 3

California Department of Corrections and Rehabilitation
Division of Correctional Health Care Services
Mental Health Program



Men's Mental Health Program Capacity Requirements

Long Term Bed Plan

Spring 2009 Projections through 2013

UPDATED – April 2010

[16] Assumptions and Footnotes
Men's Mental Health Program

ASSUMPTIONS:

This plan assumes:

—In Table A, the base bed number does not include short term proposals. In Table B, only the short term projects included are those intended to become permanent. Those short term projects intended to become permanent (as indicated in Table B) are ASH 25 bed ICF from Acute, COR 45 bed EOP-ASU, SATF 264 bed EOP (SNY and Co-occurring Disorders), SVSP 27 bed EOP-ASU and SQ 17 MHCB.

—Mental health bed need projections to 2013 using Spring 2009 population projections.

—One new facility is to be built in collaboration with the *Plata* Receiver and located near Stockton. This facility will provide care and housing appropriate to an inmate's custody level.

—All Coleman court-ordered projects are completed.

—All "temporary" projects are decommissioned. This includes *all* court identified "temporary" and *all* short term interim solutions except the 45 bed EOP-ASU expansion at COR, the 27 bed EOP-ASU expansion at SVSP, the EOP programs at SATF, and the MHCB at SQ Building 22. Court identified temporary projects include the ICF-high custody beds in D-5 and D-6 at SVSP, the MHCB at CMC and CIM, and the ICF-high custody beds at CMF. Also, the interim 20 MHCB at CMF APP revert back to Acute beds and Interim Acute beds at ASH revert back to ICF (per short-term projects plan).

—No currently operating programs will be decommissioned unless;

1) the space is being converted to another required level of mental health care; and

2) there is adequate alternative capacity to accommodate future need in that level of care.

—CDCR inmates will remain in DMH hospital beds.

FOOTNOTES (Men's Program):

1. CMC: The 36 MHCBs are interim and will be decommissioned when there is no wait list.

2. CIM: The 34 MHCBs are interim and will be decommissioned when there is no wait list.

3. SVSP: ICF High Custody beds are comprised of 128 permanent ICF beds plus 112 beds (in D-5 and D-6 housing units). The D-5 and D-6 beds will remain in place with new treatment space until there is no wait list; These are considered temporary by the Coleman Court.

4. CMF: Current ICF-low custody beds are comprised of 44 beds in the A-2 housing unit and 40 beds in the A-3 housing unit. Current ICF-high custody beds are comprised of 36 in the P-2 housing unit (as a Short Term project these beds in P-2 have been converted temporarily to Acute level of care) and 30 in the P-3 housing unit; these are considered by the Court as temporary.

5. LAC: Builds, per court order, treatment and office space for a housing unit conversion to 150 EOP beds.

6. SVSP: Additional EOP capacity results from augmenting the current EOP-ASU capacity by 27 to 72 in an existing housing unit using existing treatment and office space. The EOP GP program will move to another facility at SVSP. The new EOP facility will have office and treatment space

constructed and will add 108 additional EOP GP beds to total 300.

7. CMF: Additional treatment and office space is in the design phase for the CMF EOP (including expanded capacity) and EOP-ASU populations. The interim 20 MHCB at CMF APP revert back to Acute beds.

8. COR: As a short term proposal made permanent, EOP-ASU capacity will be designated out of existing housing; permanent treatment and office space will be built to support these services.

9. SQ: Also, related in short term proposals, the 29 MHCBs are delineated as follows: 17 MHCBs in Building 22 (Receiver's project), and 12 MHCBs within the CTC at the Condemned Inmate Complex project. The MHCB in the Condemned Inmate Complex was originally identified in the December 2006 Bed Plan (page 9) and was repeated in the August 2007 Supplemental Bed Plan (page 13). It has also been consistently identified in the bed chart spread sheets in these submittals.

10. SATF: As two short term projects made permanent, EOP capacity will be designated from existing housing, the design of which currently provides treatment and office space within the facility.

[17] ATTACHMENT A

EXHIBIT 4

Project: Convert 2 pods of 11 four person dorms to EOP-GP beds (88) Co Occurring Disorders Program
Responsible Person: Sharon Aungst
Address of Resp. Person: 801 J Street, Sacramento, California
Location: Substance Abuse Treatment Facility F Yard

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Any Sub Tasks	Status
Define Scope	78	06/16/09	06/18/09		09/30/09	09/30/09			B. Strader	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare COBCP or 30 Day Letter Funding Request. Submit to DOF for approval. Includes hiring additional staff, adding additional office and treatment space.	Completed
Define Clinical Scope	261	06/15/09	06/16/09		03/02/10	03/02/10			P McAlpin	Establish a Workgroup to address: (A) Physical Requirements to deliver EOP Mainline Services ensuring separation of EOP from GP population with secured treatment & sub program in housing areas designed to deliver Confidential Group Treatment	Workgroup established & [illegible] meeting weekly
Prepare Funding Request	55	12/17/09	12/17/09		02/19/10	03/04/10	13		W. Weldin	Obtain minor cap outlay funding for fencing	Completed
Working Drawings (Construction Documents)	113	10/07/09	10/01/09		01/27/10	02/04/10	14		W. Weldin	Conducted site visit 10/6/09; Working Drawings completed [illegible] forwarded to Warden for signature. SATF to request expedite of State Fire Marshall Approval	Completed
Construction & Retrofit	30	05/31/10			06/30/10				W. Weldin	Pending	
Hire Staff	89	01/05/10	02/08/10		04/30/10	Ongoing			P McAlpin	Advertise, Hire and Train Staff	Ongoing
Activation	145	02/01/10	02/01/10		06/25/10				P McAlpin R Coffin	Contracting for Stress Management and Recovery Training. Establish criteria for selection of clinical appropriate population for inclusion in program. Initial [illegible] occupancy: staff orientation, [illegible] supplementary placement of Group [illegible] equipment.	Training scheduled for June 2010
Phased Admissions	29	06/01/10			06/30/10				P McAlpin		

* * * *

[20] ATTACHMENT A

EXHIBIT 5

Report Date 5/13/2010

Project: Level III SAP COP program to Facility G Pods A-D
Responsible Person: Sharon Aungst
Address of Resp. Person: 501 J Street, Sacramento, California
Location: Substance Abuse Treatment Facility, Corcoran

Primary Tasks	Duration (Cal Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to [illegible]	Lead Person	Key Sub-Tasks	Status
Develop Funding Request Package	56	12/17/09	12/17/09		02/10/10	3/4/10	22		B. Wasdin	Obtain fence cap outlay funding for fencing	Completed
Architectural Engineering	261	07/23/09	07/23/09		03/16/10	2/4/10	(43)		V. Lundy	Conducted site visit 10/8/09. Working Drawings completed 01/11/10 forwarded to Warden for signature. SATF to request expedite of State Fire Marshall Approval	Completed
Construction & Retrofit	70	03/18/10	04/07/10	20	05/27/10				B. Wasdin	Fencing	Started 4/7/10-expect completion 5/26/10
PHASE I: PODS A & B OF G YARD (88 Beds)											
Hire Staff	68	01/22/10	01/22/10		03/30/10		44		P. McAleon	Advertise, Hire and Train Staff	Ongoing
Activation	242	09/01/09	09/01/09		04/30/10		13		R. Coffin	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment	Ongoing
Inmate Admissions	43	04/05/10	04/05/10		05/17/10				P. McAleon		As of 4/23/10 Pod A Full
[illegible]											
Evaluation	31	07/01/10			08/01/10				P. McAleon	Evaluate Clinical staff availability and inmate population need	
PHASE II: POD C OF G YARD (44 Beds)											
Hire Staff	31	07/01/10 or Passage of Budget			08/01/10				P. McAleon	Advertise, Hire and Train Staff	
Activation	30	08/01/10			08/31/10				R. Coffin	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment	
Inmate Admissions	26	09/01/10			09/27/10				P. McAleon		
PHASE III: POD D OF G YARD (44 Beds)											
Hire Staff		Ongoing			Ongoing				P. McAleon	Advertise, Hire and Train Staff	
Activation		Ongoing			06/30/10				P. McAleon R. Coffin	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment	
Inmate Admissions	30	06/30/10			06/30/10				P. McAleon		

Revised 5/11/10

* * * *

[26] Attachment B

[27] FOR SUBMISSION TO THE *COLEMAN* COURT

Update to Defendants' Long-Range Mental Health Bed Plan

Defendants' November 6, 2009 long-range mental health plan consists of a combination of construction projects previously ordered by the Court, new projects proposed as part of their November 6, 2009 plan, previously planned non court-ordered projects, and temporary programs that Defendants may request approval from the Court to decommission. Defendants submit this brief update to their long-range mental health bed plan in order to update the Court on the status of the construction projects previously ordered by the Court and on the new projects proposed as part of their November 6, 2009 plan.

A. *Construction Projects Ordered by the Court Prior to Defendants' November 6, 2009 Long-Range Mental Health Bed Plan.*

The preliminary plans for the EOP-ASU Treatment Space project at the California Medical Facility (CMF) are approximately 92% complete, and the preliminary plans for the EOP Treatment Space project at California State Prison, Los Angeles County, are approximately 96% complete.[1] Additionally, the working drawings for the EOP Treatment and Office Space project at California State Prison, Sacramento (SAC), are complete.

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[1] Updates on the court-ordered projects are taken from CDCR's activation schedules for the reporting period ending April 23, 2010.

The 20-bed Psychiatric Services Unit (PSU) at the California Institution for Women (CIW) is under construction: construction of the housing renovation is approximately 21% complete, and construction of the modular building is approximately 14% complete. Construction started on the 64-bed ICF project at CMF on April 15, 2010. Defendants accelerated this project by nearly one year, and patient admissions are now expected to commence on October 14, 2011.

The working drawings for the 50-bed MHCB project at California Men's Colony (CMC) are approximately 10% complete. However, pending California Environmental Quality Act litigation brought by the California Correctional Peace Officers Association (CCPOA), threatens to hinder CDCR's ability to move forward with this project. CCPOA filed a Petition for Writ of Administrative Mandamus in the San Luis Obispo Superior Court on February 4, 2010. (Docket No. 3843-3 at 1.) CDCR removed the case to the United States District Court, Central District of California, and filed a motion to transfer venue to the Eastern District of California. (*Id.*) CCPOA filed a motion to remand the case back to state court. (*Id.*) On May 7, 2010, the Central District of California granted CDCR's motion to transfer venue to the Eastern District of California, and declined to address CCPOA's motion for remand. (*Id.* at 1-4.) On May 12, 2010, Judge Karlton related this litigation—*California Correctional Peace Officers Association v. California Department of Corrections and Rehabilitation, et al.*, Case No. 2:10-cv-1131—to the *Coleman* class action litigation. (Docket No. 3844.) Additionally, Judge Karlton set a Status (Pretrial Scheduling)

Conference for August 2, 2010. (Docket No. 28, Case No. 2:10-cv-01131.) Defendants are evaluating ways to accelerate the Status Conference in light of the time lines set [28] forth in the activation schedule for the CMC 50-bed MHCB project. (*See* Ex. 1, CMC Activation Schedule.)

B. New Construction Projects Proposed as Part of Defendants' November 6, 2009 Long-Range Mental Health Bed Plan.

The 27 EOP-ASU beds at Salinas Valley State Prison (SVSP) are activated. Additionally, the Pooled Money Investment Board (PMIB) approved a loan for the initial design phase of the 152-bed PSU project at SAC on February 17, 2010, and the environmental review is underway. The PMIB also approved a loan for the initial design phase of the new Treatment and Office Space project at California State Prison, Corcoran, on February 17, 2010, and the environmental review was complete on March 29, 2010, 231 days early. The PMIB also approved a loan for the initial design phase of the 108-bed EOP-GP project at SVSP on April 21, 2010, and the environmental review is underway. In addition, the Dewitt conversion project and the EOP-GP Treatment and Office Space project at the Central California Women's Facility are currently on schedule.

Finally, Defendants sought legislative approval of the scope, schedule, and cost of the California Health Care Facility and Estrella projects. (Ex. 2.) However, the JLBC has not yet concurred with CDCR's requests to fund these projects. (*Id.*) This action has resulted in 90- and 120-day impacts on the projects, respectively.

[29] ATTACHMENT B

EXHIBIT 1

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead)/ Behind	Planned Complete	Actual Complete	Days (Ahead)/ Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
PWB Approval of Preliminary Plans	48	12/29/09	1/7/10	9	2/12/10	2/16/10	4		C. List	PWB Approval	PWB meeting changed to 2/16/10. There is no impact to the overall project schedule.
Working Drawings (Construction Documents)	187	2/15/10	2/17/10	2	8/21/10				K. Boland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	Delay due to changed PWB date. CDCR budget issues slowed the contract execution for the start of WD's. Delays have not impacted the overall schedule. WD's are approximately 10% complete.
Bid and Award	90	8/23/10			11/21/10				K. Boland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	
Construction¹	600	11/22/10			7/14/12				K. Boland Contractor TBD	Mobilize Construction Contractor, Construction Manager, Inspector of Record. Construct Project, Purchase and Install Group II Equipment, Testing of Systems (fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval	The baseline Action Plan dated May 22, 2009 and filed with the Court on May 26, 2009, reflects a reduced construction duration of 120 days. This assumes construction can be completed 4 months earlier than previously built CDCR licensed mental health facilities (i.e. 600 days instead of 720 days). CDCR is evaluating additional opportunities to accelerate construction.
Hire Staff²	543	1/10/11			7/6/12				B. Stessler J. Marshall	Advertise, Hire and Train Staff	
Prepare Final Verified Office of Statewide Health Planning and Development (OSHPD) Reports	630	10/22/10			7/14/12				TBD	Including final as-built drawings	Construction Manager and Inspector of Record to be identified prior to construction start.
Self Certification	13	7/18/12			7/31/12				D. Hysen		
License Approval	7	8/1/12			8/8/12				B. Stessler J. Marshall	DPH Survey, DPH Approval	
Activation	56	8/9/12			10/4/12				B. Stessler J. Marshall	Initial staff occupancy, staff orientation, develop policies and procedures, stock supplies/inventory, placement of Group II equipment.	
Patient Admissions	36	[illegible]			10/4/12				B. Stessler J. Marshall	Assumes Patients will be admitted at a rate of six per week.	

¹ Court Order(s) filed 3/22/07, Docket No. 2173; filed 4/18/08, Docket No. 2757; and filed 10/20/08, Docket No. [illegible]

² Special Master shall receive updates on construction every 90 days

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

Pursuant to court order, on November 6, 2009, defendants filed a detailed long-range bed plan. Included in the long-range bed plan was a proposal to renovate the former Stark Juvenile Justice facility to provide Enhanced Outpatient Program general population and administrative segregation unit beds. *See* Defendants' Long-Range Plan and Ex. 10 thereto, filed November 6, 2009. By order filed January 4, 2010, the court identified two obstacles to approval of the proposed Stark EOP conversion project (hereafter Stark): the special master's report that the proposed project would "require either an increase the amount of out of cell time for class members housed in that program, or reduction in the number of admissions, or some combination of the two", and the apparent conflict between the August 4, 2009 Opinion and Order of the three judge court requiring "defendants to 'reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity' as a necessary prerequisite to the [2] provision of constitutionally adequate medical and mental health care" and defendants' proposal to double cell inmates up to 141% of capacity in the EOP program Stark. Order filed January 4, 2010, at 2-3 (citing August 4, 2009 Opinion and Order.) Accordingly, the court declined to approve the Stark EOP conversion project as proposed and ordered defendants to file within forty-five days an amended proposal for Stark EOP conversion project.

On February 1, 2010, defendants filed a motion for reconsideration of that order. On the same day, defendants filed a request for temporary relief from the forty-five day deadline in which to file an amended proposal for Stark. By order filed February 12, 2010, defendants were granted "a period of ninety days in which to file an amended bed plan for the EOP population targeted for the Stark facility together with either a new notice resetting the hearing on their motion for reconsideration, *see* Local Rul 230, or a notice withdrawing said motion." Order filed February 12, 2010, at 1-2.

On May 13, 2010, defendants filed an amended proposal for the EOP population initially targeted for the Stark facility together with a notice renewing that part of their motion for reconsideration that sought relief from that part of the January 4, 2010 order that required them to limit the population for Stark to no more than 137.5% of the facility's design capacity.[1] In their renewed motion, defendants suggest that amendments to the plan have addressed the Special Master's concerns regarding out cell time and number of admissions, and they state that the pertinent portions of their motion for reconsideration will be withdrawn if court finds these amendments to be adequate. On June 4, 2010, plaintiffs filed a response to defendants' amended plan and renewed motion for reconsideration. Plaintiffs object only to the fact that the activation schedule submitted with the amended plan now calls for completed activation and patient admissions under the amended proposal in December 2014, rather than the 2013 date that [3] defendants originally represented would be the end point for completion of all long-range projects. Plaintiffs request that the court approve the amended proposal "subject to submission within thirty days of a new activation schedule for the Stark project that reflects patient admission completed to full occupancy by 2013." Plaintiffs' Response, filed June 4, 2010, at 3. In their reply, defendants contend that plaintiffs' request is "extraneous" and "beyond the scope" of the matters at bar. Defendants' Reply, filed June 14, 2010, at 7.

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[1] On May 14, 2010, defendants filed an amended notice of renewal of their motion for reconsideration, amending the noticed hearing date to this court's June 21, 2010 regular law and motion calendar.

Turning first to defendants' motion for reconsideration, the special master has reported to the court that the amended proposal meets the concerns that he identified with respect to the original proposal. Accordingly, that portion of defendants' motion for reconsideration will be deemed withdrawn. Defendants also renew their motion for reconsideration of that part of the January 4, 2010 order that required them to limit the population at Stark to no more than 137.5% of the facility's design capacity. Defendants' request is based in part on the fact that implementation of the population limit ordered by the three judge court, on which this court's January 4, 2010 order was predicated, was stayed by the three judge court on January 12, 2010 pending review by the

United States Supreme Court. In light of the stay, that provision of this court's January 4, 2010 order is lifted pending completion of that review. Nothing in this order shall be construed in any way to conflict with or contradict any finding of the three judge court.

Turning to plaintiffs' objections, the need for the EOP beds to be created or made permanent pursuant to the amended proposal before the court is undisputed. It is also beyond dispute that an urgent need for those beds exists today. As the court has noted repeatedly, this action has been in the remedial phase for over fifteen years, and at no time during that entire period have defendants had sufficient beds to meet their constitutional obligations to members of the patient class. Waiting four more years to complete the beds that are the subject of the amended proposal before the court is simply unacceptable. Accordingly, defendants will be directed to file within fifteen days from the date of this order a detailed statement identifying every step that might be taken to accelerate the project at each and every stage thereof. [4] Defendants shall identify all actions required to accomplish such steps, including but not limited to waivers of state law, and shall identify the amount of time that can be saved by each step.[2]

In accordance with the above, IT IS HEREBY ORDERED that:

1. Defendants' February 1, 2010 motion for reconsideration, renewed on May 14, 2010, is dropped from calendar.

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[2] The Stark project is a joint project with the *Plata* Receiver. Accordingly, defendants shall consult with the Receiver as appropriate in developing this list.

2. Within fifteen days from the date of this order defendants shall file a detailed statement identifying every step that might be taken to accelerate the project at each and every stage thereof. Defendants shall identify all actions required to accomplish such steps, including but not limited to waivers of state law, and shall identify the amount of time that can be saved by each step.

DATED: June 15, 2010.

/s/ Lawrence K. Karlton
Lawrence K. Karlton
SENIOR JUDGE
UNITED STATES DISTRICT COURT

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

SPECIAL MASTER'S REPORT ON DEFENDANTS' REVIEW OF SUICIDE PREVENTION POLICIES, PRACTICES, AND PROCEDURES

Matthew A. Lopes, Jr., Esq.
Special Master
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September 27, 2010

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[29] Based on the discussions with defendants that took place during my work group's meetings and teleconferences with them, my experts and I disagree with the interpretation that defendants now appear to be giving the Program Guide provisions on OHUs, and presumably with whatever Program Guide textual modifications which defendants may be con-

sidering. Their apparent interpretation contradicts the intent behind the resolution of past negotiations surrounding the lack of access to MHCBs, when the impetus for creation of OHUs was to provide at least a temporary safety valve from a dangerous insufficiency of MHCB care. Defendants' interpretation of what is proper use of OHUs is not currently, and historically was never intended to be, within accepted use of OHUs. They were conceived of, and eventually agreed to by the parties, as a stop-gap measure to provide at least a temporary safety net for inmates potentially in need of crisis level care, and those awaiting transfer to such care. They were never considered a destination placement for conduct of suicide watch, suicide precautions, or prolonged assessment and/or treatment of serious mental illness or suicidality.

Back in November 2001, former special master J. Michael Keating said in his Report on Defendants' Plan to Expedite Access to a Mental Health Crisis Bed (MHCB) Level of Care:

> . . . [V]estiges of the historical problem[14] linger. There is a departmental policy, currently in the process of revision and clarification, which permits OHUs to hold for up to 72 hours inmates who require crisis intervention or further observation and evaluation of behavior that may indicate mental illness. The policy calls for a reevaluation at 24 and 48 hours and requires that arrangements be made for transfer to a higher level of care, if the inmates' mental health needs continue beyond 48 hours. The policy is not unreasonable. Seriously mentally disordered

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[14] i.e. delays in transfers of inmates to MHCBs.

inmates can become briefly agitated or depressed and need some isolation and quiet, which may suffice to restore equanimity relatively quickly. Similarly, inmates with no prior mental health involvement may manifest temporarily [30] symptoms of a mental disorder in the correctional environment, especially during the reception process. A rigid requirement to transfer immediately every agitated inmate who enters an OHU makes no sense. As long as the OHU transfers an inmate as soon as it becomes clear that he or she needs, for example, a MHCB level of stabilizing care, the 72-hour observation period is acceptable.

Problems occur when a clearly psychotic inmate arrives in an OHU and is "observed" or evaluated" there for 72 hours, without the supervision, monitoring, and treatment that can be provided in CDC only in a MHCB setting. Such a situation, not a far-fetched scenario, is exacerbated when local clinicians and administrators in an OHU believe they can treat and stabilize inmates as well as, or better than, clinicians in MHCB units. In practice, severely mentally ill inmates sometimes remain in an OHU for anywhere from three to ten or more days before a referral is made to a MHCB unit elsewhere. The expedited transfer process, now available and successful, may mean the inmate gets to a MHCB level of care within 24 hours of the referral, an important improvement, but local clinical hubris and/or lack of confidence in the clinical skills of a MHCB unit elsewhere had delayed needed care, diverted local resources and, perhaps, created a potentially dangerous situation for a psychotic inmate.

Special Master's Report on Defendants' Expedited Process for Transfers to a Mental Health Crisis Bed Level of Care, November 15, 2001, p. 5-6 (emphasis added) (Exh. G).

It also must be remembered that this is not merely an academic debate or a discussion of proper legal construction of the Program Guide. At its heart, this is a matter of sound clinical practice. My experts believe that clinical standards call for referral and transfer of suicidal patients to an MHCB within 24 hours of their having been found suicidal while under observation and evaluation in an OHU. The level of care for inmates who have been deemed to require suicide precaution or suicide watch triggers a prompt referral and transfer. My experts and I recommend rejection of any proposal by defendants for Program Guide modification to allow expanded or prolonged observation or evaluation of suicidal inmates in OHUs longer than 24 hours after they have been found to be suicidal, and in any event no longer than 72 hours after they were placed in [31] an OHU. Suicide precaution and suicide watch in an OHU may continue only if and as long as no MHCB is available.

V. *The Special Master's Review of Suicides in 2008 and 2009*

In the interest of expediting the suicide prevention and review process, and in recognition of defendants' apparent re-dedication to improving its performance in suicide review and reporting, I asked the parties to suggest a streamlined report format for my expert's annual suicide report on the 37 suicide deaths in calendar year 2008 and the 25 suicide deaths in 2009. Plaintiffs requested (Exh. B., p. 6-7), and the defendants have agreed ((Exh. C., p. 4), that these two reports may consist of:

- A statistical summary.
- Chart 1[15], which covers suicides, by CDCR or DMH facility.
- Chart 2, which covers single-cell housing, incarcerated "R" suffix, method, history of suicidal behavior, history of mental health treatment, housing Keyhea, severe or life-threatening illness, presence on the mental health caseload at the time of death, significant indication of inadequate treatment, etc.
- Findings, including whether defendants complied with timelines of their own suicide review and reporting process, and the percentage of suicides that were foreseeable and/or preventable.
- Table 1, with all elements.
- Table 2, with all elements.

I agree, and recommend, that the reports for 2008 and 2009 be prepared and submitted in the summarized fashion suggested above.[16] Although it is important to continue and preserve the ongoing record of suicide reviews through those years, it is equally important to quickly bring the full suicide review process into the present calendar year, as some of the new suicide prevention strategies are already being put into place. Unfortunately, the data for 2010 so far is not showing improvement in suicide [32] prevention. As of this writing, there have been 26 suicides in CDCR in 2010, and it is only September. The need for vigilance in solving this problem continues. The goal is now to encourage the focus of resources on the implementation of these various new strategies and any needed refinement thereof, as may become apparent in the review process. The sooner this process is begun, the better. It is no exaggeration to say that lives are at stake.

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[15] The charts and tables requested by plaintiffs refer to the charts and tables that have appeared in my expert's annual suicide reports to date.

[16] I reject both Defendants' and plaintiffs' requests and suggestions with regard to the methods my expert may wish to employ to complete his review, or as to his submission of any individual written case reviews. (Exh. B, p. 7, footnotes 3, 4; Exh. C, p. 4)

VI. *Plaintiffs' Additional Proposals*

In their letter to me dated September 8 (Exh. B), plaintiffs' counsel offered the following additional requests which were not proposed in defendants' Report:

A. *Changes to Defendants' Handcuff Policy in Mental Health Crisis Bed Units*

Plaintiffs state that the defendants' policy for use of mechanical restraints in MHCB units violates applicable licensing standards and existing Program Guide provisions governing the use of such restraints, and maintains a non-therapeutic MHCB environment. They want the defendants' policy to be changed. (Exh. B., p. 2-3). The use of mechanical restraints within the MHCB units raises some interesting and provocative issues, and is worthy of further discussion. However, this topic would be more appropriately taken up in the policy meeting process than in this context.

B. *Suicide-Resistant Beds in Mental Health Crisis Bed Units*

Plaintiffs request that suicide-resistant beds be furnished for MHCB units, and that those units at San Quentin State Prison and California Medical Facility which have such beds should make use of them. (Exh. B., p. 3-4). This is an important concern that plaintiffs have raised previously with defendants, but which remains unresolved. There have been informal reports that in the absence of suicide-resistant beds in some MHCB

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EXHIBIT A

[1] FOR SUBMITTAL TO THE *COLEMAN* SPECIAL MASTER

DEFENDANTS' *AMENDED* AUGUST 25, 2010 UPDATED REPORT ON ACTIVITIES TAKEN FOLLOWING THE COURT'S APRIL 14, 2010 ORDER

* * * *

- [9] Construction of New Small Management Yards: CDCR completed this project on June 20, 2009. This project was envisioned prior to the onset of the 2006 plan.

- "Bad News" Screening: CDCR successfully implemented this proposal by adding questions to the CDCR Form 7277 Initial Health Screening. CDCR administers this questionnaire to all inmates passing through the Receiving & Release process.

- Retrofitting of ASU Intake Cells: CDCR completed this project as of January 31, 2009.

- Additional emergency response training including CPR: CDCR completed this training program in the Fall of 2007 and continues to hold drills on a monthly basis.

- Daily coordination meetings in ASU: These meetings occur each morning throughout the CDCR system in order to identify inmates in need of services and new arrivals in ASU.

- Screening prior to placement in ASU: CDCR coordinated implementation of this procedure with the CPHCS Nursing administration.

Training was provided to all nursing in the field by videoconference in July 2007.

By comparison, those parts that have been partially implemented and remain subject to ongoing auditing and refinement are as follows:

- Explore the feasibility of providing entertainment devices in ASU: The Department conducted the feasibility study and found that only nine institutions could not provide power for entertainment devices.
- Upon placement into ASU, inmates are housed in retrofitted intake cells for 72 hours: Population pressures have adversely impacted full implementation of this provision. After completion of initial construction, reviews of procedure and practice have revealed that additional modifications may be necessary to fully implement this provision.
- Custody welfare checks required every 30 minutes during the first 21 days in ASU: This provision has been successfully implemented throughout CDCR institutions and CDCR is continuing to refine its audit process.
- Priority for out-of-cell time for new arrivals in ASU: CDCR directed the institutions to implement this procedure, but fully implementing it has been difficult due to population pressures creating difficulty auditing the out-of-cell time for new arrivals.
- Reducing length of stay in ASU: Local audit teams have succeeded in reducing the length of stay for many inmates. At all CDCR institutions, upon an inmate's placement in the

ASU, the inmate is tracked in the institution's local ASU tracking

* * * *

[1] IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
SACRAMENTO DIVISION

[Filed: 10/19/10]

2:90-cv-00520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

DEFENDANTS' UPDATE TO COURT RE: CONSTRUCTION AND FUNDING OF DEFENDANTS' AMENDED STARK PLAN

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[2] Acronym List

Term	Definition
AB	Assembly Bill
CDCR	California Department of Corrections and Rehabilitation
CEQA	California Environmental Quality Act
DOF	Department of Finance
JLBC	Joint Legislative Budget Committe
PMIB	Pooled Money Investment Board
PWB	Public Works Board

[3] I. INTRODUCTION

After consulting with the *Coleman* Special Master, Defendants submit this summary of some of their previous submissions regarding the Stark project in an effort to clarify any uncertainty about those submissions.[1] In addition, Defendants take this opportunity to update the Court on their efforts to obtain financing for the project.

II. SUMMARY OF STARK CONSTRUCTION UPDATES

Defendants proposed in November 2009 renovating the Stark Juvenile Justice Facility to an adult facility to house and treat Enhanced Outpatient Program-General Population and Enhanced Outpatient Program-Administrative Segregation Unit inmates. (Docket No. 3724-2 at 7.) Defendants' original proposal had a projected completion date of September 23, 2014. (*Id.* at 44.) The Court declined to approve Defendants' proposal on January 4, 2010, and ordered Defendants to submit an amended proposal that "limits the population for that facility to no more [than] 137.5% of the facility's design capacity and that meets the concerns identified by the special master." (Docket No. 3761 ¶ 1.c.) On May 13, 2010, Defendants submitted an amended proposal to the Court that reflected a December 15, 2014 full occupancy date for the Stark facility (amended Stark plan). (Docket Nos. 3845, 3845–2 at 4.) Although six months passed since Defendants submitted their original proposal to the Court, their amended proposal reflected a full occupancy date only three months later than their original proposal. On June 15, 2010, this Court found that Defendants' amended Stark plan met the concerns identified by the Special Master with respect to the original proposal, and stayed the requirement that the plan limit the population for that facility to no more than 137.5% of the facility's design capacity pending review by the United States Supreme Court. (Docket No. 3856 at 3:7–17.) Notwithstanding this finding, this Court ordered that Defendants identify steps that might be taken to accelerate Defendants' amended Stark plan. (Docket No. 3856 ¶ 2.)

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[1] Defendants' earlier submissions, however, speak for themselves, and Defendants do not intend this summary to conflict with or supersede any statements or representations made in their earlier pleadings in this Court.

[4] On June 30, 2010, Defendants identified two steps responsive to the Court's order: (1) use of the "design-build" procurement method for construction of the amended Stark plan under Government Code section 14661.1(i), which Defendants anticipated would accelerate the project by 8 months—from December 2014 to April 2014; and (2) waiver of three California Environmental Quality Act (CEQA) notice periods that, if waived by the Court, could accelerate the CEQA process by 85 days. (Docket No. 3870 at 4:14–5:21.)[2]

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[2] Those notice periods are: (1) Cal. Pub. Res. Code § 21091(a); Cal. Code Regs. tit. 14, § 15105(a) (provides a 45-day time period for public review of the draft EIR); (2) Cal. Pub. Res. Code § 21092.5(a); Cal. Code Regs. tit. 14, § 15088(b) (provides that at least 10 days prior to certifying the final EIR, the lead agency shall provide a written proposed response to a public agency on comments made by that agency); and (3) Cal. Pub. Res. Code § 21108(c); Cal. Code Regs. tit. 14, § 15094(f) (provides that a Notice of Determination must be posted and available for public inspection for 30 days). (Docket No. 3870 at 5:21–6:3.)

On July 21, 2010, Defendants updated the Court regarding the first step. Defendants notified the Court that the Department of Finance (DOF) concurred with the request by the California Department of Corrections and Rehabilitation (CDCR) to use the "design-build" procurement method for construction of the amended Stark plan. (Docket No. 3885.) Although this action occurred eight months after Defendants originally proposed to convert the Stark facility, Defendants nonetheless accelerated the project's estimated completion date by eight months, from December 2014 to April 2014. (Docket No. 3870 at 5:6–10.)

On July 30, 2010, Defendants updated the Court regarding the second step. Consistent with the Court's June 15, 2010 order, Defendants previously identified several "actions required to accomplish [this] step[]," including the need for Joint Legislative Budget Committee (JLBC) approval, and an unqualified bond opinion regarding the validity of the bonds that will be used to construct the project. (Docket No. 3870 at 6:8-15.) In Defendants' July 30, 2010 update, Defendants notified the Court that bond counsel conditionally concluded that the Court could waive the CEQA notice periods without having an adverse impact on the viability of the bonds. (Docket No. 3889 at 2:18–27.) In addition, Defendants continued to work to identify other ways to accelerate the project. (*Id.* at 3:3–8.)

[5] On August 30, 2010, Defendants identified a third step responsive to the Court's June 15, 2010 order. Defendants determined that a phased occupancy approach to the amended Stark plan could potentially accelerate the full occupancy date for the four new Enhanced Outpatient Program population

housing units by four months—from April 2014 to December 2013. (Docket No. 3904.) This step was independent from the second step, and would potentially accelerate the project by four months irrespective of whether the Court also waived the CEQA notice periods. (*Id.* at 3:15–20.) Nonetheless, as with the second step, Defendants also identified several actions that would be required to accomplish this step, and Defendants maintained that the current April 2014 activation schedule, which involves fewer uncertainties, would be a more reasonable approach for the amended Stark plan. (*Id.* at 3:20–22.)

III. UPDATE REGARDING DEFENDANTS' REQUEST FOR ASSEMBLY BILL 900 FUNDING FOR THE AMENDED STARK PLAN

Even while Defendants continued working to identify ways to accelerate the project's completion, they also sought funding for the project. As previously indicated, Defendants will fund the amended Stark plan through Assembly Bill (AB) 900 lease-revenue financing authority that the California Legislature appropriated to construct capital prison projects. (Docket No. 3845–2 at 8; Hysen Decl. ¶ 4.) Under state law, Joint Legislative Budget Committee (JLBC) approval is required for this AB 900 project to proceed. (Hysen Decl. ¶ 4; Cal. Gov't Code § 15819.40(d).)

On August 18, 2010, the Department of Finance (DOF) notified the JLBC of CDCR's request for AB 900 funding for the amended Stark plan. (Hysen Decl. ¶ 4, Ex. 1.) Additionally, a September 20, 2010 Public Works Board (PWB) meeting was scheduled to "establish" the project scope, cost, and schedule for the amended Stark plan. (*Id.* ¶ 5.) And a September 23, 2010 Pooled Money Investment Board (PMIB) meeting was scheduled to request interim financing.

(*Id.*) Obtaining approval of the scope, cost, and schedule for the amended Stark plan from the PWB and obtaining interim financing for the amended Stark plan from the PMIB are both required steps in the AB 900 financing process for the amended Stark plan. (*Id.*)

[6] On September 15, 2010, the JLBC notified DOF that, at that time, the JLBC could not concur with CDCR's request for AB 900 funding for the amended Stark plan. (Hysen Decl. ¶ 4, Ex. 1.) Specifically, the JLBC stated: "The Legislature will reconsider this project when the state's fiscal and budget situation are more settled and the department has provided a plan for how it will cost-effectively expand prison capacity within the level of resources authorized by AB 900." (*Id.*) Defendants are providing this Court with a copy of the JLBC's September 15, 2010 letter in order to apprise the Court of this recent development. Because the JLBC would not concur with CDCR's request for AB 900 funding for the amended Stark plan, and the JLBC's approval is a prerequisite to the PWB and PMIB meetings, the project was taken off the PWB and PMIB calendars. (*Id.* ¶ 5.)

Nonetheless, CDCR is continuing to work with the JLBC to obtain its approval to use AB 900 funds for the amended Stark plan. (Hysen Decl. ¶ 6.) Specifically, CDCR officials met with the Chair of the JLBC, Senator Denise Moreno Ducheny, in the third week of September to discuss the concerns outlined in the JLBC's September 15, 2010 letter. (*Id.*) Based on that meeting, CDCR has developed additional information to provide the JLBC to address the concerns outlined in the letter and seek concurrence and to place the project on the agenda for an upcoming PWB meeting. (*Id.*)

CDCR expects that the earlier removal of the amended Stark plan from the PWB's calendar based on the JLBC's inability to concur with the project will result in a "day-for-day" delay, commencing on the date that CDCR expected to receive PMIB funding; that is, from September 23, 2010, until the project is resubmitted for PWB approval and receives PMIB funding. (Hysen Decl. ¶ 7.) Thus, CDCR expects a delay from the current April 2014 full occupancy date for the [7] amended Stark plan. (*Id.*) The full extent of the delay, however, will not be known until such time as the JLBC approves the project, and the PWB and PMIB meetings are rescheduled. (*Id.*)

Dated: October 19, 2010

Respectfully submitted,

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[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA SACRAMENTO DIVISION

[Filed: 10/19/10]

2:90-cv-00520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

DECLARATION OF DEBORAH HYSEN IN SUPPORT OF DEFENDANTS' UPDATE TO COURT RE: CONSTRUCTION AND FUNDING OF DEFENDANTS' AMENDED STARK PLAN

I, Deborah Hysen, declare:

1. I am employed by the California Department of Corrections and Rehabilitation (CDCR) as the Chief Deputy Secretary of Facility Planning, Construction, and Management. I am competent to testify to the matters set forth in this declaration and if called upon to do so, I would and could so testify. I submit this declaration in support of Defendants' Update to the Court Re: Construction and Funding of Defendants' Amended Stark Plan.

2. I have served as the Chief Deputy Secretary of Facility Planning, Construction, and Management since June 2007. I am responsible for the overall

management and oversight of CDCR construction projects for all its institutions.

[2] 3. I am familiar with Defendants' amended Stark plan, which was filed with this Court on May 13, 2010: Defendants' amended Stark plan proposes to build four new units to provide housing, treatment, and office space for inmates requiring an Enhanced Outpatient Program level of care. It also incorporates the 30-bed Mental Health Crisis Bed project that is an integrated part of the new 60-bed Correctional Treatment Center planned for the Stark facility. CDCR also plans to construct a new Central Health Services Building at the facility. All three projects are part of a cooperative effort between CDCR and the *Plata v. Schwarzenegger* Receiver.

4. CDCR is funding the amended Stark plan through Assembly Bill (AB) 900 lease-revenue financing authority that the California Legislature appropriated to construct capital prison projects. Under state law, Joint Legislative Budget Committee (JLBC) approval is required for this AB 900 project to proceed. The California Department of Finance (DOF) notified the JLBC of CDCR's request for AB 900 funding for the amended Stark plan on August 18, 2010. On September 15, 2010, the JLBC declined to concur with CDCR's request for AB 900 funding for the amended Stark plan. A true and correct copy of the JLBC's September 15, 2010 letter is attached as Exhibit 1.

5. A September 20, 2010 Public Works Board (PWB) meeting was scheduled to establish the scope, cost, and schedule for the amended Stark plan. Additionally, a September 23, 2010 Pooled Money Investment Board (PMIB) meeting was scheduled to request interim financing. Obtaining approval of the

scope, cost, and schedule for the amended Stark plan from the PWB and obtaining interim financing for the amended Stark plan from the PMIB are both required steps in the AB 900 financing process for the amended Stark plan. Because the JLBC would not concur with CDCR's request for AB 900 funding for the amended Stark plan, and the JLBC's approval is a prerequisite to the PWB and PMIB meetings, the project was taken off the PWB and PMIB calendars.

6. CDCR is working with the JLBC to obtain its approval to use AB 900 funds for the amended Stark plan. Specifically, CDCR officials met with the Chair of the JLBC, Senator Denise Moreno Ducheny, in the third week of September to discuss the concerns outlined in the [3] JLBC's September 15, 2010 letter. Based on that meeting, CDCR has developed additional information to provide the JLBC to address the concerns outlined in the letter and seek concurrence and to place the project on the agenda for an upcoming PWB meeting.

7. CDCR expects that the earlier removal of the project from the PWB's calendar based on the JLBC's inability to concur with the project will result in a " day-for-day" delay, commencing on the date that CDCR expected to receive PMIB funding; that is, from September 23, 2010, until the project is resubmitted for PWB approval and receives PMIB funding. Thus, CDCR expects a delay from the current April 2014 full occupancy date for the amended Stark plan. The full extent of the delay, however, will not be known until such time as the JLBC approves the project, and the PWB and PMIB meetings are rescheduled. Meanwhile, CDCR is providing a copy of the JLBC's letter in order to apprise the Court of current developments.

I declare under penalty of perjury that the foregoing is true. Executed this 19 day of October 2010, at Sacramento, California.

/s/ DEBORAH HYSEN
DEBORAH HYSEN

EXHIBIT 1

[1] Joint Legislative Budget Committee

[Logo]

Chair

Denise Moreno Ducheny

Senate

Vacant
Mark DeSaulnier
Robert Dutton
Bob Huff
Christine Kehoe
Alex Padilla
Lois Wolk

Vice Chair

Bob Blumenfield

Assembly

Anthony Adams
Wilmer Amina Carter
Kevin De Leon
Noreen Evans
Felipe Fuentes
Roger Niello
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GOVERNMENT CODE SECTIONS 9140-9143

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September 15, 2010

Ms. Ana J. Matosantos, Director
Department of Finance
Room 1145, State Capitol
Sacramento. California 95814

Dear Ms. Matosantos:

In a letter dated August 18, 2010, you notified the Joint Legislative Budget Committee of your request on behalf of the California Department of Corrections and Rehabilitation (CDCR) for allocations of funds from lease-revenue, bonds authorized in Chapter 7, Statutes of 2007 (AB 900, Solorio), to convert the existing, deactivated Heman G. Stark Youth Correctional Facility to an adult male correctional facility with approximately 2,840 beds. The facility will be a Reception Center and also provide housing for inmates requiring Enhanced Outpatient Program (EOP) mental health treatment as well as permanent work crew inmates. In, addition, the facility will include a 60-bed Correctional Treatment Center (CTC) with medical and mental health crisis beds. The EOP and CTC beds are part of CDCR's plan to provide constitutionally adequate medical and mental health care as required by the federal *Plata* and *Coleman* courts. The estimated total project cost is $518.8 million, considering allocations from both AB 900 appropriations for infill projects and health care projects.

Ongoing Annual Costs. While the current shortage of reception center beds and the federal courts directives for adding health care beds suggest the need to move forward with this project quickly, I am concerned with moving forward with this project at this time given the state's fiscal condition and the uncertainty surrounding the state's budget situation. This facility, once operational, will cost the state a net of about $100 million annually for operations and debt service. In light of the drastic cuts to state programs already enacted and more still to be determined, it seems prudent to wait before committing to the level of new ongoing spending recommended by CDCR.

Less Costly Alternatives Not Explored. In addition, I am concerned that the department has not thoroughly explored whether the proposed project is, in fact, the most cost-effective way to [2] add additional capacity. According to staff, the department has not yet conducted an analysis to determine whether a new facility with greater capacity could be constructed at the same or lower cost. Failure to do this type of cost comparison analysis is alarming coming in a time of diminished state resources. It is critical to ensure that limited state construction dollars are used as efficiently as possible.

Other Phase I Projects in Jeopardy. Finally, I am concerned that the department's current expenditure plan for Phase I AB 900 infill and health care projects exceeds the total authorized appropriation, yet the department has provided my staff with no plan for how it will complete the remaining projects still to be authorized. Specifically, AB 900 authorized a total of $1,800.000,000 for Phase I infill projects and $710,940,000 for Phase I health care projects. However, the department's most recent plan, dated August 25, 2010, identifies a need of $1,939,000,000 and $755,000,000 for Phase I infill and health care projects, respectively. These overages suggest that the department will have to either scale back its construction plan or come to the Legislature for additional appropriations.

Conclusion. Accordingly, at this time, I cannot concur with CDCR's request for the allocation of funding and the establishment of the scope, cost, and schedule for the conversion of the Heman G. Stark Correctional Facility. The Legislature will reconsider this project when the state's fiscal and budget situation are more settled and the department has provided a plan for how it will cost-effectively expand prison capacity within the level of resources authorized by AB 900.

It is also my expectation that CDCR will continue to assess the construction costs associated with this project and its overall AR 900 construction plan. In particular I expect the department will address the concerns raised r this letter with respect to ensuring that the current proposal is the most cost-effective option for increasing reception center and EOP housing capacity, as well as addressing the failure of the current construction plan to stay within existing appropriation.

Sincerely

/s/ Denise Moreno Ducheny
Denise Moreno Ducheny
Chair

Cc: Members of the Joint Legislative Budget Committee

FOR ARGUMENT

Supreme Court, U.S.
FILED
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No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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NOTICE

The following documents have been omitted from the printing of this Deferred Joint Appendix. They may be found in the Appellants' Appendix to the 09-416 Jurisdictional Statement at the following pages:

Coleman v. *Schwarzenegger/Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK JFM P, C01-1351 TEH (E.D. Cal./N.D. Cal. Aug. 4, 2009) (population reduction plan opinion and order) 1a

Coleman v. *Schwarzenegger/Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK JFM P, C01-1351 TEH (E.D. Cal./N.D. Cal. Nov. 3, 2008) (order denying motion for dismissal) 257a

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Coleman v. *Schwarzenegger*/*Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK-JFM-P, C01-1351-TEH (E.D. Cal./N.D. Cal. Jan. 12, 2010) (order to reduce prison population) 1a

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[1] UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

[Filed: June 13, 2002]

No. C-01-1351 T.E.H.

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
GRAY DAVIS, *et al.*
Defendants.

STIPULATION FOR INJUNCTIVE RELIEF

INTRODUCTION

1. The parties enter into this stipulation to address issues pertaining to medical care services provided by the California Department of Corrections (CDC). The plaintiffs are California state prisoners who have serious medical needs. The defendants include the Governor, Director of Finance, Youth and Adult Correctional Agency Secretary, Director of Corrections, and Deputy Director, Health Care Services Division, and are sued in their official and individual capacities as state officials responsible for the operation of the CDC and its health care delivery system.

2. This action was filed by plaintiffs on April 5, 2001, and an amended [2] complaint was filed on August 20, 2001. The action alleges that plaintiffs are not receiving constitutionally adequate medical care as required by the Eighth Amendment to the U.S. Constitution and that defendants are not complying

with the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.

3. The parties have conducted informal negotiations since July 1999, in an effort to resolve plaintiffs' demand that medical services be improved. Those negotiations have been undertaken at arm's length and in good faith between plaintiffs' counsel and high ranking state officials and their counsel. The parties have reached agreement on procedures that the parties will follow in this case for resolving disputes concerning the constitutional adequacy of medical services. The parties freely, voluntarily, and knowingly with the advice of counsel enter into this Stipulation for that purpose.

WHEREAS, a dispute exists between the parties as to the extent to which CDC's provision of inmate-medical care meets constitutionally-mandated minimum standards;

WHEREAS, this dispute arose over the course of the last fifteen years, and culminated in plaintiffs filing this statewide-medical class action;

WHEREAS, the Governor of the State of California over the past three years has allocated substantial new resources to improve the medical system and is committed to continuing the improvements to meet applicable standards;

WHEREAS, this stipulation is intended to be narrowly drawn to meet those applicable standards.

A. Terms and Conditions

4. The CDC shall implement Health Care Services Division Policies and Procedures (Policies and Procedures), to be filed with the Court on February 15, 2002. Defendants shall make all reasonable efforts to secure the funding necessary to implement the

Policies and Procedures. The Policies and Procedures are designed to meet or exceed [3] the minimum level of care necessary to fulfill the defendants' obligation to plaintiffs under the Eighth Amendment of the United States Constitution. It is the intent of this Stipulation to require defendants to provide only the minimum level of medical care required under the Eighth Amendment. Nothing in this stipulation shall be construed to require more of the defendants than is necessary to enforce the Eighth Amendment of the United States Constitution. Any disputes as to whether defendants' Policies and Procedures and the Audit Instrument will satisfy their obligations under the Eighth Amendment shall be resolved pursuant to the dispute resolution procedures set forth in ¶ ¶ 26-28.

5. The CDC shall implement the Policies and Procedures at each prison pursuant to the following schedule, which may be rearranged for the purpose of grouping or clustering improvements pursuant to ¶ 24 below:

Calendar Year[1] 2003:	Northern California Women's Facility, Valley State Prison for Women, California State Prison - Corcoran; High Desert State Prison, California State Prison - Sacramento, and Salinas Valley State Prison.[2]

---

[1] The Calendar Year begins on January 1st and ends on December 31st.

[2] If, pursuant to ¶ 8, below, the district court determines that prisoners at the California Institution for Women and the Central California Women's Facility are part of the plaintiff class, the Policies and Procedures shall be implemented at these prisons in Calendar Year 2003.

Calendar Year 2004: California Correctional Institution, Mule Creek State Prison, San Quentin State Prison, Substance Abuse Treatment Facility, and California State Prison – Solan.

Calendar Year 2005: Centinela State Prison, California Institute for Men, California Men's Colony, California Medical Facility, and North Kern State Prison-II (Delano II).

Calendar Year 2006: California Rehabilitation Center, Deuel Vocational Center, Folsom State Prison, California State Prison - Los Angeles County, and Pleasant Valley State Prison.

[4] Calendar Year 2007: California Correctional Center, Calipatria State Prison, Chuckawalla Valley State Prison, North Kern State Prison, and Richard J. Donovan Correctional Facility.

Calendar Year 2008: Avenal State Prison, Correctional Training Facility, Ironwood State Prison, Sierra Conservation Center, and California State Prison-Wasco.

Prior to Calendar Year 2003, CDC shall initiate appropriate hiring procedures to hire medical staff for employment beginning January 1st.

6. Beginning January 1, 2003 defendants shall implement the following practices or procedures at each institution:

a. Registered Nurses shall staff the emergency clinics 24 hours per day every day.

b. Inter-institution transfers shall occur pursuant to the protocol established in the Policies and Procedures.

c. Treatment protocols set forth in the Policies and Procedures will be implemented at all institutions subject to the availability of additional resources.

d. A priority ducat system consistent with CDC regulations shall be instituted.

e. Outpatient special diets will be available for patients with liver and kidney end-stage organ failure.

7. The parties understand and agree that the 602/inmate-grievance procedure is an integral part of the provision of essential medical care and is integrated into the Policies and Procedures. Accordingly, the parties agree that, in the first instance, all complaints regarding medical care to an individual inmate, except those requiring urgent medical care, shall be submitted to defendants after utilizing the inmate grievance procedure. If after the appeal has reached the third director's level of review and all administrative relief has been exhausted, or the CDC has not responded to the inmate's appeal within 30 days at the Director's level of review and plaintiffs contend that the grievance process has failed to adequately address the problem, plaintiffs may bring the [5] medical care concern to the attention of defense counsel, who shall respond in writing within

30 days. Plaintiffs' counsel may also contact the Chief Medical Officers at the institutions to inquire about the care furnished to particular inmates on a monthly basis. Defendants' counsel shall be notified about such contacts.

8. The parties agree that this action shall be maintained as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure and that the class consists of all prisoners in the custody of the CDC with serious medical needs, except those incarcerated at Pelican Bay State Prison. The parties disagree about whether prisoners incarcerated at the California Institution for Women (CIW) and the Central California Women's Facility (CCWF), previously litigated in a class action entitled *Shumate v. Wilson* (E.D. Cal.) CIV S-95-0619 WBS JFM P, should be members of the class. To resolve this dispute defendants shall move within sixty days after this Stipulation is approved by the Court for an order determining whether prisoners at CCWF and CIW should be excluded from the class on the sole ground that they are not similarly situated to plaintiffs because of the previously litigated class action entitled. The motion will not otherwise alter the burden of proof under Rule 23 or create a presumption concerning their inclusion.

B. Access to Information

9. Subject to the limitations set forth in this Stipulation, plaintiffs' counsel and the experts shall have reasonable access to the institutions, staff, inmates and documents necessary to properly evaluate the adequacy of the medical care delivery system and the proposed remedies therefor, including the Policies and Procedures and the Audit Instrument, the schedule and other items required by this Stipula-

tion. The parties shall cooperate so that plaintiffs' counsel and the experts have reasonable access to information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants.

[6] 10. Plaintiffs' counsel and defendants shall negotiate a discovery plan for informal discovery that shall provide to plaintiffs' counsel information from the Department of Corrections' headquarters and from individual institutions about the medical services available to members of the plaintiffs' class, the adequacy of any remedial measures proposed or undertaken by defendants, and defendants' compliance with this Stipulation. Periodic monthly meetings will be scheduled between defendants' and plaintiffs' counsel to discuss stipulation implementation and access to information.

11. The discovery plan shall include, but not be limited to, access to the following documents and other material subject to a protective order agreed to by the parties:

a. The complete medical files of members of the plaintiff class as reasonably necessary;

b. Internal reviews and audits of the medical services provided to members of the plaintiffs' class, including QMAT and 602 survey;

c. Non-privileged documents that relate to the amount budgeted for providing medical care to prisoners. No documents reflecting the budget for any particular upcoming budget year shall be discoverable until after the release of the Governor's Budget. This is not intended to prohibit the production of policy and planning documents.

d. Documents maintained at individual institutions and memoranda transmitted to CDC headquarters from individual institutions that are reasonably relevant to assessing defendants' compliance, including but not limited to;

  (1) All audits of medical care,

  (2) Emergency Response Drill Reports,

  (3) Summary of Emergency Responses,

  (4) Medical Staff Vacancy Reports,

  (5) Medical Staff Training Statistics,

  (6) Inter-institution Transfer Log for medical transfers,

  [7] (7) Key indicator reports as are available,

  (8) Medical related inmate appeals (602's) and responses, and

  (9) Medical Log Books

e. Plaintiffs shall not have access to personnel files.

f. The parties have been unable to agree on whether plaintiffs must be provided with the minutes of continuous quality improvement meetings, including attachments, and death reviews, utilization management data logs, and other peer review documents. The parties agree the Court will decide this issue.

g. Plaintiffs' counsel shall be given access to CDC training related to implementation of this Stipulation for the first year that any such training is offered on any medical topic.

12. Plaintiffs' counsel and their medical consultants shall have the opportunity to conduct no more

than one tour at an institution per calendar quarter, with a maximum of 40 tours in total for all institutions each calendar year. Tours shall be scheduled in a manner consistent with the requirements of this Stipulation and generally in accordance with the priorities established by the schedule promulgated pursuant to ¶ 5. Plaintiffs' counsel may resume tours based upon a finding of substantial noncompliance pursuant to ¶ 15.

13. Tours by plaintiffs' counsel shall include reasonable access to housing units and all facilities where medical services are provided. Defendants shall make reasonable efforts to make available for interview departmental, custodial, clinical and program staff that have direct or indirect responsibility for providing medical services to class members. Defendants shall direct institution staff to reasonably cooperate with plaintiffs' counsel and the experts in obtaining the necessary information. Plaintiffs' counsel shall be able to have reasonable brief discussions with inmates during the tours and shall be able to provide business cards with their name and address for distribution to specified individual inmates. Defendants will also continuously post notices informing [8] all inmates at each institution that complaints regarding the provision of medical care may be sent to counsel for the plaintiff class in this case. Defendants also shall provide plaintiffs' counsel reasonable access to confidential interviews with inmates before or after the tours, during regular business hours without regard to regular visiting hours and days. Upon a request by plaintiffs' counsel at least two weeks prior to the tour, defendants shall make available for inspection and/or copying the medical files of specified inmates. If the need arises within one week prior to the tour, plaintiff's counsel

may designate additional medical files for inspection and/or copying.

14. If any party fails to make himself or herself, an employee, or an agent reasonably available for interview and the parties agree, the other party may depose the party, the employee, or agent who has not been made available. If the parties are unable to agree, the court may order such deposition of the party, employee, or agent if such deposition is reasonably necessary to the conduct of the litigation.

15. Plaintiffs' counsel and their medical consultants will cease tours at an institution after a particular institution has been found to be in substantial compliance as set forth in ¶ 22, below. Tours may resume at a particular institution if the experts find, or in the event a party disagrees with the experts, the Court finds there has not been substantial compliance on the part of defendants, provided that such tours shall be limited to the issue or components not found to be in substantial compliance. Non-compliance may be corrected by substantial compliance with the existing Policies and Procedures or by modifying the Policies, Procedures and Audit Instrument pursuant to ¶ 24 and complying with the Policies and Procedures as modified. Any disputes about whether an institution is in substantial compliance shall be resolved pursuant to the procedures set forth in ¶ 26-28, below.

C. Independent Court Experts

16. The parties agree to jointly request that the Court appoint experts pursuant to Federal Rules of Evidence, Rule 706 to advise the Court on the adequacy and [9] implementation of defendants'

Policies and Procedures and any other matter that appropriately may be the subject of the experts' testimony. The parties shall propose to the Court that the experts' duties specified in Exhibit A shall be provided to the experts pursuant to Rule 706(a). The experts shall be entitled to reasonable compensation in an amount approved by the Court and the costs for each expert shall be borne by defendants.

17. The parties agree that the Court should appoint Joe Goldenson, M.D., Michael Puisis and Maddie LaMarre as Rule 706 experts. In the event that any of these experts can no longer serve, the parties shall attempt to agree on a replacement(s) within 30 days. In the event the parties cannot agree, they shall nominate experts in accordance with Rule 706 of the Federal Rules of Evidence. The parties understand and agree that the court may appoint a mutually agreeable fourth expert in the future. In the event that the parties are unable to agree on a fourth expert, the court may appoint a fourth expert in accordance with Rule 706 of the Federal Rules of Evidence.

18. With reasonable notice and subject to the limitations set forth in this Stipulation, the Court experts shall have reasonable access to all parts of any institution, all relevant documents, all individuals (including unprivileged interviews with staff or inmates), medical meetings, proceedings and programs to the extent that such access is reasonably needed to fulfill his or her obligations. If both parties agree, the court experts may hire additional personnel, at defendants' expense, to assist them in performing their duties. If both parties cannot agree, the court may authorize the hiring of additional personnel, at defendants' expense, upon a showing by the court experts that such additional personnel

are reasonably necessary to the performance of their duties.

D. Compliance

19. Defendants shall audit each prison's compliance with the Policies and Procedures consistent with the schedule set forth in ¶ 5, above.

20. Compliance with the Policies and Procedures shall be audited by using an Audit Instrument which will be filed on February 15, 2002. This Audit Instrument [10] will be developed by the CDC in consultation with the independent court experts and plaintiffs' counsel. The parties recognize that this instrument has not been tested and may need to be modified to properly reflect the degree of actual compliance. No later than January 15, 2004, the parties and the independent court experts shall meet and confer about the need to modify the audit instrument. If all parties agree, the instrument shall be modified. Any dispute about the need for modification shall be resolved pursuant to paragraph 18 of the Stipulation for Injunctive Relief.

21. The audit shall be conducted as follows:

a. No less than 180 Unit Health Records will be reviewed.

b. The records shall be selected at random, but the selection shall be stratified so that each category in the audit instrument is adequately represented.

c. If defendants disagree with the appropriateness of an expert's answer to any question(s) in the audit instrument relating to the quality of medical care, the question(s) shall be reviewed by both expert physicians and shall only count against compliance if both experts agree.

22. A prison is in substantial compliance when all of the following conditions are satisfied:

a. The prison receives a score of 85% or higher on an audit conducted by the Court experts of the implementation of the Policies and Procedures using the Audit Instrument identified in ¶ 20. No score less than 85% shall be considered to satisfy this requirement, except that the experts shall have the discretion to find a prison providing adequate medical care in compliance if it achieves a score of no less than 75%. The score shall be calculated by averaging all of the indicators in the audit instrument.

[11] b. In determining substantial compliance, the experts will have to ascertain whether medical assessments or treatment plans provided to inmates comply with the Policies and Procedures. The medical assessment or treatment plan provided to the inmate shall be deemed adequate and appropriate under these policies and procedures only under any one of the following conditions:

(1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or

(2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures and that such deviation is consistent with the community standard; or

(3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.[3]

In those instances in which a court expert finds that an assessment or treatment plan does not comply with community standards, defendants may request that the question(s) be reviewed by both expert physicians and shall only count against compliance if both experts agree.

c. The prison is conducting minimally adequate death reviews and quality management proceedings.

[12] d. The prison generally has tracking, scheduling and medication administration systems adequately in place.

e. At least two experts have not concluded that there is a pattern or practice that is likely to result in serious problems and those problems are not being adequately addressed.

23. Defendants shall notify plaintiffs and the court experts in writing when they believe an institution has achieved substantial compliance. Within 60 days of such notification, the experts shall conduct an audit to determine substantial compliance. If the experts find substantial compliance, the experts shall return a year later, or as soon thereafter as possible, to determine whether the institution has maintained substantial compliance.

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[3] As it is used here and throughout the policies and procedures, the phrase "community standard" means the standard of care imposed under the laws of the State of California upon health care providers licensed to practice in California.

E. Modification

24. Defendants may modify the Policies and Procedures, and the Audit Instrument at any time, provided that as modified the Policies and Procedures and the Audit Instrument will meet or exceed the minimum level of care necessary to fulfill defendants' obligation to plaintiffs under the Eighth Amendment of the United States Constitution. Defendants will provide plaintiffs' attorneys with a copy of the original Policies and Procedures or the Audit Instrument, the modified version and a strikeout version with the changes at least 30 days prior to implementation. In an emergency or when such delay will adversely affect the provision of medical care, notice will be provided as soon as possible, but no later than the date the policy is implemented. If the plaintiffs determine that the modifications conflict with any of the provisions of this Stipulation, they shall cooperate with the defendants to reconcile the conflict. Any disputes about whether the modifications will satisfy defendants' obligations under the Eighth Amendment shall be resolved pursuant to the dispute resolution procedures set forth in ¶ ¶ 26-28.

[13] 25. Plaintiffs also may seek to modify the Policies and Procedures and the Audit Instrument at any time to secure the minimum level of medical care necessary to fulfill the defendants' obligation to plaintiffs under the Eighth Amendment of the United States Constitution. Plaintiffs must submit the proposed modification to defendants. Any disputes as to whether defendants' Policies and Procedures, and the Audit Instrument must be modified to satisfy their obligations under the Eighth Amendment shall be resolved pursuant to the dispute resolution provisions set forth in ¶ ¶ 26-28.

F. Dispute Resolution

26. If plaintiffs contend that the Policies, Procedures and Audit Instrument, as written or as modified, or any component thereof will not provide for the minimum level of medical care necessary to fulfill the defendants' obligations to plaintiffs under the Eighth Amendment of the United States Constitution, plaintiffs shall provide defendants with a brief description of the perceived deficiencies and a request that the parties enter into negotiations to resolve the question as to whether defendants' Policies, Procedures and Audit Instrument satisfies the minimum requirements of the Eighth Amendment. Upon receipt of plaintiffs' request for negotiations, any party may inform the Court's experts of the area of disagreement and request that the experts evaluate the issue and prepare a report.

27. At the option of any party, the parties shall conduct negotiations on any issue in dispute. Such negotiations may include the Court's experts, and a person satisfactory to the parties may at the election of either party, mediate any unresolved issues. If the parties cannot agree on a mediator, the administrator of a private dispute resolution service, such as JAMS will choose a mediator. Defendants shall pay the cost of any private mediator. The substance of the mediation and any statements made by a party, an employee of a party, or an agent of a party are confidential and not admissible in any subsequent proceeding. The Experts' report(s) shall be admissible as evidence at the request of any party in any judicial proceeding in this case.

[14] 28. If the process set forth in the preceding paragraph fails to resolve the issue of whether defendants' Policies and Procedures and Audit Instrument,

either as written or as modified, provides for a level of medical care sufficient to meet the minimum requirements of the Eighth Amendment of the United States Constitution, either party shall have the option of seeking relief from the Court. If the court determines that defendants' Policies and Procedures and the Audit Instrument either as written or as modified, does not provide a level of medical care sufficient to meet the minimum requirements of the Eighth Amendment of the United States Constitution, the Court may grant relief as authorized under the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626(a), which provides, in pertinent part: "The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right."

G. Enforcement

29. The Court shall find that this Stipulation satisfies the requirements of 18 U.S.C. § 3626(a)(1)(A) and shall retain jurisdiction to enforce its terms. The Court shall have the power to enforce the Stipulation through specific performance and all other remedies permitted by law. Neither the fact of this stipulation nor any statements contained herein may be used in any other case or administrative proceeding, except defendants, CDC, or employees thereof reserve the right to use this Stipulation and the language herein to assert issue preclusion and res judicata in other litigation seeking class or systemic relief. When these legal defenses are raised, defendants will send copies of such complaints to plaintiffs' counsel at the Prison Law Office.

30. If plaintiffs believe that defendants are not complying with some or all of the Stipulation, or any of the acts required by the Policies and Procedures produced pursuant to Stipulation, they shall notify defendants of the perceived problems. Defendants shall investigate the allegations and respond within 30 calendar days. If [15] plaintiffs are not satisfied with defendants' response, the parties shall conduct negotiations to resolve the issue. The negotiations may include the Court's experts, and a person satisfactory to the parties may at the election of either party, mediate any unresolved issues. If the parties cannot agree on a mediator, the administrator of a private dispute resolution service, such as JAMS, will choose a mediator. Defendants shall pay the cost of any private mediator. The substance of the mediation and any statements made by a party, an employee of a party, or an agent of a party shall be confidential and not admissible in any subsequent proceeding. The Experts' report(s) shall be admissible as evidence at the request of either party in any judicial proceeding in this case. If the parties are unable to resolve the issue by negotiation or mediation, the court shall determine whether defendants are substantially complying with some or all of the Stipulation, or any of the acts required by the Policies and Procedures.

H. Termination

31. Notwithstanding the Prison Litigation Reform Act or any other law, defendants may move to vacate this Stipulation and dismiss the case on the ground that each institution subject to this stipulation has been found to be in substantial compliance under ¶ ¶ 22-23. Non-compliance may be corrected by compliance with the existing Policies and Procedures or by modifying the Policies and Procedures pursuant

to ¶ 24 and complying with the Policies and Procedures as modified. The parties shall attempt to negotiate any disputes about defendants' compliance pursuant to ¶ ¶ 26-28, and either party may invoke the enforcement process set forth in ¶ ¶ 29-30. The final determination of such a dispute shall rest with the Court.

IT IS SO STIPULATED AND AGREED.

Dated: 1-25-02

/s/ DONALD SPECTER
DONALD SPECTER
Attorney for plaintiffs

Dated: 1-2-02

/s/ ROBERT PRESLEY
ROBERT PRESLEY
Secretary for the Youth and Adult
Correctional Agency

Dated: 1/2/02

/s/ EDWARD S.ALAMEIDA, JR.
EDWARD S.ALAMEIDA, JR.
Director, California Department of Corrections

Dated: 1/2/02

/s/ PETER J.SIGGINS
PETER J.SIGGINS
Chief Deputy Attorney General
Attorney for Defendants Davis and Gage

[18] Dated: 1/2/02

BILL LOCKYER,
Attorney General of the State of California
PETER J. SIGGINS,
Chief Deputy Attorney General

ROBERT R. ANDERSON,
Chief Assistant Attorney General
PAUL D. GIFFORD,
Senior Assistant Attorney General

/s/ PETER SIGGINS
Chief Deputy Attorney General

Attorneys for Defendants Davis, Gage,
Presley, Alameida, and Pickett

THE COURT SO FINDS AND IT IS SO ORDERED.

Dated: 6/13/02

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
United States District Judge

[1] UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

[Filed Sep 17 2004]

No. C-01-1351 T.E.H.

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

STIPULATED ORDER RE QUALITY OF PATIENT CARE AND STAFFING

Based on the expert reports dated July 9 and July 16, 2004, the parties propose the following order to address the issues raised by the experts relating to quality of patient care and staffing.

A. EVALUATION OF PHYSICIANS

1. Defendants shall, within sixty (60) days of this order, engage an independent entity approved by the parties and the Court experts to evaluate and train physicians employed by the California Department of Corrections (CDC). Any agreement regarding the independent entity shall be reviewed by the Court experts and plaintiffs' counsel before it is entered into by defendants.

[2] 2. Defendants shall work with the Court experts to develop a plan to assess and train nurse practitioners and physician assistants and shall provide the plan to the Court and plaintiffs by November 1, 2005.

3. Defendants shall complete the evaluation and, if appropriate, training of all physicians with clinical responsibilities, excluding psychiatrists, at the calendar year 2003-2005 roll-out institutions by December 31, 2005. Defendants shall complete the evaluation and, if appropriate, training of all such physicians at the remaining institutions by December 31, 2006. Defendants will develop a schedule with the independent entity and provide it to the plaintiffs and the Court experts. The schedule shall provide that physicians identified by defendants as most in need of evaluation and training be given priority. Defendants will provide plaintiffs and the Court experts with monthly progress reports beginning January 15, 2005.

4. Defendants shall complete the evaluation and, if appropriate, training of all other CDC physicians with clinical responsibilities, including but not limited to, QMAT physicians, the Chief Deputy of Clinical Services, and any Assistant Deputy Director with a medical degree by June 30, 2005.

5. After the evaluation, the independent entity shall classify each person evaluated according to the following categories:

A. Category 1: competent to provide care to class members without remedial training;

B. Category 2: competent to provide care to class members pending successful completion of remedial training by the independent entity;

C. Category 3: not competent to provide care to class members, or failed to successfully complete remedial training required by the independent entity.

6. The independent entity will determine the physicians competent to treat high-risk patients (see paragraph 13).

[3] 7. Defendants shall ensure that those providers who are in Category 2 are promptly provided remedial training by the independent entity, and shall assign them to positions in a manner consistent with the evaluation.

8. Defendants shall provide plaintiffs' counsel and the Court experts with the evaluations of the physicians in the monthly document production that follows the receipt of the written evaluations.

9. Upon notification by the independent entity, physicians in Category 3 shall not engage in direct patient care, direct the activities of persons engaged in patient care, prepare or supervise the preparation of case histories, supervise persons engaged in patient care, or participate in any oversight or management of patient care.

10. Every physician hired after January 1, 2005, through December 31, 2008, must, as a condition of probation, successfully complete the evaluation and remedial training process within the first four months of employment. Defendants shall not continue to employ physicians who do not successfully complete the program. By June 30, 2008, the Court experts shall report to the Court as to whether the successful completion of the evaluation and training program should continue to be a necessary condition of probation.

11. If there are vacant physician and surgeon positions that cannot be filled with Category 1 or 2 primary care physicians, the vacant positions can be reclassified and filled with nurse practitioners or

physician assistants in ratios developed in consultation with the Court experts.

12. As of January 15, 2005, defendants shall not hire as independent contractors primary care physicians who are not board-eligible or board-certified in internal medicine or family practice.

B. TREATMENT OF HIGH-RISK PATIENTS

13. Defendants and the Court experts shall jointly develop criteria and a method to identify high-risk patients by September 30, 2004. Defendants shall identify all patients who meet the criteria, beginning with the 2003 roll-out institutions.

[4] 14. The parties and the Court experts shall develop a Plan for completing the identification and treatment of high-risk patients at all the institutions and submit it to the Court.

15. Defendants shall take all necessary steps to ensure that high-risk patients are treated by primary care providers that are designated to treat such patients.

16. By November 1, 2004, independent physicians approved by the Court experts shall evaluate and treat high-risk patients housed at California State Prison - Sacramento (CSP-SAC), California State Prison Corcoran (COR), Central California Women's Facility (CCWF), and Salinas Valley State Prison (SVSP). Defendants shall ensure that adequate nursing and administrative support is provided at each institution to assist the independent physicians with scheduling and follow-up of patient care. If the Court experts determine that additional independent physicians are needed at other institutions, the experts shall submit a report to the Court and

parties. The independent physicians at the four designated institutions shall continue until the experts report that those prisons have sufficient qualified providers caring for high-risk patients or that defendants have some other program to provide adequate care to those patients.

C. PHYSICIAN AND NURSING CLASSIFICATIONS AND SUPERVISION

17. By November 1, 2005, defendants shall submit a proposal to the appropriate control agencies to reclassify all physician categories and include a classification for regional medical directors. A market survey and reclassification study shall be completed prior to submission of the proposal. The proposal shall also include a recommendation that each institution have a qualified health administrator and a qualified medical director. The proposal shall also address the need for salary adjustments. In the interim, and until defendants' proposal is implemented, defendants shall hire additional central office and regional medical directors, of a type and number agreed to by the Court experts. By December 1, 2004, defendants shall submit to the Court a plan to hire and retain central office and regional medical directors.

[5] 18. By November 1, 2005, defendants shall also submit a proposal to the appropriate control agencies for a director of nursing and a classification for regional directors of nursing. The proposal shall also address the need for salary adjustments. In the interim, and until defendants' proposal is funded, defendants shall hire a Director of Nursing and regional directors of nursing, of a type and number agreed to by the Court experts. By December 1, 2004, defendants shall submit to the Court a plan to hire

and retain central office and regional directors of nursing.

19. Defendants shall change the hiring process from a local process to a regional or central process for all physician, nurse practitioner, and physician assistant categories. By January 15, 2005, defendants shall submit to the Court a plan to modify the hiring process.

20. By March 1, 2005, defendants shall develop a plan to expand the agreement, referenced in paragraph 1, to include a program approved by the parties and the experts for on-site clinics through a residency program affiliation, which will provide medical care for inmate patients with complex medical conditions. Defendants' plan shall provide that the on-site clinics be established for the calendar year 2003-2005 roll-out institutions as practicable by March 1, 2006.

21. By March 1, 2005, defendants shall work with the Court experts to complete statewide health care bylaws and credentialing policy and submit to the Court a scheduled plan for implementation of the process after training is completed. The credentialing policy shall include provisions requiring advanced qualifications for those providers caring for high-risk patients.

22. By December 1, 2005, defendants shall work with the Court experts to complete peer review policy and submit to the Court a scheduled plan for implementation of the process after training is completed.

D. QMAT AND OTHER SUPPORT POSITIONS

23. By March 1, 2005, defendants shall fund, establish, and begin to fill one position at each of the roll-out institutions to support the implementation of the [6] Inmate Medical Scheduling and Tracking System (SATS-LITE). Defendants will begin recruiting for the positions no later than January 1, 2005, with the intention of filling positions as soon as they are established.

24. By March 1, 2005, defendants shall fund, establish, and begin to fill not less than nine positions to expand the Quality Management Assistant Teams (QMAT). Defendants will begin recruiting for the positions no later than January 1, 2005, with the intention of filling positions as soon as they are established.

E. MISCELLANEOUS

25. In the event that defendants fail to meet or believe they will be unable to meet any deadline in this Stipulation and Order, the parties and the Court experts shall meet and confer and submit a joint report to the Court identifying any problem and the appropriate action to be taken.

26. This order is necessary to correct a current and ongoing violation of a federal right, extends no further than necessary to correction the violation of the federal right, and is narrowly drawn and the least intrusive means to correct the violation.

IT IS SO STIPULATED.

Date: September 10, 2004

/s/ Steven Fama
Steven Fama
Attorney for Plaintiffs

Date: September 10, 2004

/s/ Tami M. Warwick
Tami M. Warwick
Deputy Attorney General
Attorney for Defendants

PURSUANT TO THE STIPULATION, IT IS SO ORDERED.

Date: 9/17/04

/s/ Thelton E. Henderson
Honorable Thelton E. Henderson
United States District Court Judge

[1] IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

NO. CO1-1351 TEH

MARCIANO PLATA, *et al*,,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al*.,
Defendants.

CLASS ACTION

FINDINGS OF FACT AND CONCLUSIONS OF LAW RE APPOINTMENT OF RECEIVER

INTRODUCTION

On June 30, 2005, after six days of evidentiary hearings, this Court ruled from the bench that it would establish a Receivership to take control of the delivery of medical services to all California state prisoners confined by the California Department of Corrections and Rehabilitation ("CDCR"). The purpose of this written decision is to amplify upon this Court's June 30, 2005 oral ruling by providing the specific Findings of Fact and Conclusions of Law that underlay this decision, as well as to address further proceedings in this case.

By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action. The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system. This statistic, awful as it is, barely provides a [2] window into the waste of human life occurring behind California's prison walls due to the gross failures of the medical delivery system.

It is clear to the Court that this unconscionable degree of suffering and death is sure to continue if the system is not dramatically overhauled. Decades of neglecting medical care while vastly expanding the size of the prison system has led to a state of institutional paralysis. The prison system is unable to function effectively and suffers a lack of will with respect to prisoner medical care.

Accordingly, through the Court's oral ruling and with this Order, the Court imposes the drastic but necessary remedy of a Receivership in anticipation that a Receiver can reverse the entrenched paralysis and dysfunction and bring the delivery of health care in California prisons up to constitutional standards. Once the system is stabilized and a constitutionally adequate medical system is established, the Court will remove the Receiver and return control to the State. Progress toward that goal will be enhanced and quickened by the support of the defendants. Fortunately, the Court is confident that the leaders of the State prison system recognize the gravity of the problem and are committed to facilitating the Receivership.

PROCEDURAL BACKGROUND

Plaintiffs filed this class action on April 5, 2001, alleging that defendants were providing constitutionally inadequate medical care at all California state prisons.[1] Defendants agreed to enter into a consent decree and to implement comprehensive new medical care policies and procedures at all institutions. *See* June 13, 2002 Stipulation for Injunctive Relief. The Stipulated Injunction provides in part: "The Court shall have the power to enforce the Stipulation through specific performance and all other remedies [3] permitted by law." It also provides that it "shall be binding upon, and faithfully kept, observed, performed and be enforceable by and against the parties." *Id.* at 14. Defendants also agreed to the court appointment of medical and nursing experts to assist with the remedial process. *See* June 13, 2002 Order Appointing Experts.

Defendants were ordered to implement new policies and procedures on a staggered basis, with seven prisons to complete implementation in 2003, and five additional prisons for each succeeding year until state-wide compliance is achieved. The Court Experts submitted a report on July 16, 2004 which found an "emerging pattern of inadequate and seriously deficient physician quality in CDC facilities." July 16, 2004 Report (part 2) at 1. In response, defendants agreed to address the very serious issues identified in the report through a Stipulated Order re Quality of Patient Care and Staffing, which this Court approved on September 17, 2004 ("Patient Care Order"). The Patient Care Order required defendants to engage an independent entity to (a) evaluate the competency of physicians employed by the CDCR and (b) provide training to those physicians found to be deficient. It also required defendants to undertake certain measures with respect to the treatment of high-risk patients, to develop proposals regarding physician and nursing classifications and supervision, and to fund and fill Quality Management Assistance Teams ("QMAT") and other support positions. Defendants failed to come close to meeting the terms of the Patient Care Order, even with generous extensions of time from the Court.

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[1] This suit exempts Pelican Bay State Prison, which is under Court jurisdiction in the case of *Madrid v. Woodford*, No. C90-3094 TER. *See* June 13, 2002 Stipulation for Injunctive Relief at 3-4.

On May 10, 2005, this Court issued an Order to Show Cause ("OSC") as to (1) why a Receiver should not be appointed to manage health care delivery for the CDCR until defendants prove that they are capable and willing to do so without Court intervention, and (2) why defendants should not be held in civil contempt of this Court's prior orders. On May 31, and June 1-2 and 7-9, 2005, the Court conducted an evidentiary hearing in which the parties presented evidence relating to the OSC. That evidence took the form of testimony from the Court Experts, state employees in positions critical to the prison medical system, and the state's medical consultant, as well as eighty-two exhibits.

[4] On May 17 and June 1, 2005, the Court received correspondence from the president of the Service

Employees International Union ("SEIU") Local 1000, on behalf of SEIU and other unions representing state prison medical personnel, asking to participate in the evidentiary hearings. The Court responded by inviting the unions to submit an amicus brief.

The parties subsequently submitted legal briefs addressing the issues of contempt and Receivership in light of the evidence elicited at the hearing, and the unions filed an amicus brief. On June 30, 2005 the Court held a hearing on the OSC. Based on the arguments of counsel, the evidence presented, the full record in this case, and the Court's own observations on prison tours, the Court delivered an oral ruling at the conclusion of the hearing that it would take control of the medical delivery system of the CDCR and place it under the auspices of a Receivership. This Order is consistent with that ruling and provides a full discussion of the Court's findings of fact and conclusions of law.

FINDINGS OF FACT

A. Background

1. Over the past 25 years, the California correctional system has undergone a vast expansion in size and complexity. Ex. 42 at 1 (Governor's Reorganization Plan 2 – "A Government for the People for a Change: Reforming California's Youth and Adult Correctional System"). Since 1980, the inmate population has grown well over 500 percent and the number of institutions has nearly tripled from 12 to 33. *Id.* Currently, the CDCR has approximately 164,000 inmates, 114,000 parolees, and 45,200 employees. *Id.* at 1, 3.

2. Defendants concede that this rapid growth of the correctional system was not accompanied by

organizational restructuring to meet increasing system demands and that it requires fundamental reform in a variety of areas, including management structure, information technology and health care services in order to function effectively and in compliance with basic constitutional standards. *Id.* at 6-7.

3. A prevailing lack of accountability within California's struggling correctional system has resulted in a failure to correct basic problems and an increase in tell-tale signs of [5] dysfunction. *Id.* at 5. The CDCR has functioned for years under a decentralized structure in which individual wardens wielded extensive independent authority in determining prison standards and operating procedures. *Id.* These "operational silos" resulted in a lack of accountability and responsibility among the various institutions. *Id.*

4. In the area of health care services, the consequences of system expansion without reform have been shocking. The Department's annual health care budget has risen to over $1 billion. Ex. 41 at 103 (06/04 "Reforming Corrections" – Report of the Corrections Independent Review Panel, Chapter 6 – Risk Management and Care). The CDCR's spending on health care is so poorly managed, however, that this increase in budget has been tantamount to throwing good (taxpayer) money after bad.

B. Defendants' Failure to Provide Constitutionally Adequate Medical Care has Caused Plaintiffs Extreme Harm

5. As required by the Court's June 13, 2002 Stipulation for Injunctive Relief, the Court's Medical Experts visited nine prisons that had begun implementation of the inmate Medical Policies and

Procedures. Reporter's Transcript of Evidentiary Hearing ("RT") 263:9-14 (Lail Marre); RT 28:19-22 (Puisis); RT 339:11-340:10 (Goldenson). As set forth in their reports, the Experts concluded that defendants' failure to implement the required remedies had the effect of placing CDCR prisoners at serious risk of harm or death. See, e.g., Exs. 5164 and 95 (reports by Court Experts regarding conditions in various prisons). The extensive and disturbing findings of the Expert's reports are essentially uncontested, and the Court finds that they accurately describe an extreme crisis in CDCR's medical delivery system.

(1) Lack of Medical Leadership

6. The leaders of the CDCR medical system lack the capability and resources necessary to deliver adequate health care, much less fix the abysmal system that now exists. Dr. Rene Kanan, Acting Director of Health Care Services for the CDCR, testified that the CDCR lacks an adequate system to manage and supervise medical care, both in the central office and at nearly all of its prisons. RT 572:1-5 (Kanan).

[6] 7. Indeed, Undersecretary of Corrections Kevin Carruth testified that medical care simply is not a priority within the CDCR, is not considered a "core competency" of the Department, and is "not the business of the CDC, and it never will be the business of the Department of Corrections to provide medical care." RT 554: 445. Mr. Carruth could not even estimate when significant improvements to the system might be made if the State were left to its own devises. RT 549:1-4 (Carruth); RT 571:11-22 (Kanan).

8. In order to implement medical care policy, Dr. Kanan must seek assistance from non-medical administrators with higher authority. RT 727:22-729:7 (Rougeux). To make matters worse, many prison medical staff believe that the warden is their "real boss" even though organization charts indicate that medical staff report to Dr. Kanan. RT 243:3-16 (Puisis). The Court finds, as defendants' own expert consultant Dr. Ronald Shansky testified, that the Deputy Director is inhibited "internally, organizationally," and in her dealings with external governmental organizations to implement Court Orders because the Deputy Director lacks the perceived and ultimate authority over the health care program. RT 671:14M672:15 (Shansky).

9. Furthermore, central office staff do not have the tools they need to handle the vast quantity of information necessary to manage a billion dollar, 164,000 inmate system. RT 545:8-546:10 (Carruth). Data management, which is essential to managing a large health care system safely and efficiently, is practically non-existent. RT 138:8-139:4; 140:3-9 (Puisis). The CDCR's system for managing appointments and tracking follow-up does not work. RT 140:12-24 (Puisis). These data management failures mean that central office staff cannot find and fix systemic failures or inefficiencies. As just one of innumerable examples, there are patients in the general prison population who need specialized housing, but the CDC does not track them and headquarters staff is unaware of how many specialized beds are needed. Ex. 48 at 4.

10. The CDCR is aware of the actions required to improve the prison health care system, but its leaders have not been able to address issues requiring

systemic change. RT 390:19-391:22 (Goldenson), RT 152:23-154:5 (Puisis). For example, although the Experts noted [7] repeatedly in reports to the CDCR headquarters staff that the health care delivery system in San Quentin posed "a risk of imminent harm and death to patients," it took a year for the CDCR to take notice, due in part to a "lack of resource capacity in the Health Care Services Division to address problems at multiple sites." Ex. 56 at I (04/09/05 Expert LaMarre's Report on San Quentin State Prison from February 7-8, 2005 Visit). Dr. Kanan frankly testified that the CDCR lacks an adequate system to manage and supervise medical care. RT 572:1-5 (Kanan).

11. The State reorganized the prison system into a new organizational structure effective July 1, 2005. Ex 86 (Department of Corrections and Rehabilitation Organization Chart). While the new structure holds promise for some improvements in the Department, it fails to provide sufficient authority to the medical leadership, and may well exacerbate the problems that currently exist. RT 677:844 (Shansky). The highest ranking health care operations director is several levels down from the Secretary in the organizational hierarchy, and thus does not have sufficient authority. RT 670:11-19 (Shansky); RT 149:18-152:1 (Puisis). The new organization also splits health care operations and policy, thereby creating unnecessary room for conflict and inefficiency. RT 677:15-23 (Shansky).

12. The Court finds that the CDCR leadership simply has been – and presently is – incapable of successfully implementing systemic change or completing even minimal goals toward the design

and implementation of a functional medical delivery system.

(2) Lack of Qualified Medical Staff

a. Medical Administrators

13. Of the higher level management positions in the CDCR's Health Care Services Division, 80% are vacant, making effective supervision or management impossible. RT 572:6-8 (Kanan); RT 543:10-16 (Carruth). This is akin to having a professional baseball team with only a relief pitcher and no infielders.

14. Furthermore, the CDCR has not hired regional medical directors as ordered. RT 392:20-25 (Goldenson). These regional medical directors are needed to provide supervision of medical staff at the institutional level. RT 93:11-94:17 (Puisis). Court Expert Goldenson [8] accurately described the absence of regional management, coupled with incompetent prison staff, as resulting in "the blind leading the blind." RI 387:21-388:10 (Goldenson).

15. There also is no central office leadership in nursing. This makes it difficult to initiate and ensure compliance with nursing policy and practice. Ex. 48 at 6 (07/09/04 Plata Experts' Second Report, Part One); RT 270:1-17 (LaMarre). Moreover, there is a severe shortage of nursing supervisors at the prisons. RT 274:12-19 (LaMarre).

b. Physicians

16. The CDCR sorely lacks sufficient qualified physicians to provide adequate patient care to prisoners. While there certainly are some competent and dedicated doctors working within the system, they are unable to service even a fraction of the entire prisoner population. RT 682:14-22 (Shanksy).

Many other CDCR physicians are inadequately trained and poorly qualified as, for many years, CDCR did not have appropriate criteria for selecting and hiring doctors. RT 669:4-17 (Shansky). Dr. Shansky testified that historically the CDCR would hire any doctor who had "a license, a pulse and a pair of shoes." RT 669:7-9 (Shanksy). According to Dr. Puisis, 20-50% of physicians at the prisons provide poor quality of care. RI 51:17-19(Puisis). Many of the CDCR physicians have prior criminal charges, have bad privileges revoked from hospitals, or have mental health related problems. Ex. 49 at 3 (07/16/04 Plata Experts' Second Report, Part Two); Ex. 54 at 1 (03/17/05 Email from Expert Puisis re: Visit to Substance Abuse Treatment Facility State Prison ("SATF")). An August 2004 survey by CDCR's Health Care Services Division showed that approximately 20 percent of the CDCR physicians had a record of an adverse report on the National Practitioner Databank, had a malpractice settlement, had their license restricted, or had been put on probation by the Medical Board of California. RT 580:1-7 (Kanan). The Court Experts testified that the care provided by such doctors repeatedly harms prisoner patients. RT 350:18-355:21 (Goldenson); RI 51:12-13 (Puisis). The Court finds that the incompetence and indifference of these CDCR physicians has directly resulted in an unacceptably high rate of patient death and morbidity.

[9] 17. Inadequate medical care in CDCR is due not merely to incompetence but, at times, to unprecedented gross negligence. RT 366:25-367:4 (Goldenson). Indeed, the evidence from multiple sources establishes that medical care too often sinks below gross negligence to outright cruelty. Ex. 54 at 1; RT 74:6-75:8 (Puisis).

18. The Court will give just a few representative examples from the testimonial and documentary evidence. In one instance, a prisoner reported a two to three week history of fever and chills and requested care. RT 346:940 (Goldenson). The prisoner repeatedly visited medical staff with an increasingly serious heart condition but was consistently sent back to his housing unit. RT 347:1-19 (Goldenson). Eventually, the patient received a correct diagnosis of endocarditis, a potentially fatal heart condition treatable with antibiotics, but did not get appropriate medication. *Id.* Finally, the prisoner went to the prison emergency room with very low blood pressure, a high fever and cyanotic (blue) fingertips, indications of seriously deficient blood flow and probable shock. RT 347:20-25; 350:3-10 (Goldenson). Despite the objections of a nurse who recognized the severity of the prisoner's condition, the physician attempted to return the patient to his housing unit without treatment. RT 348:1-5 (Goldenson). Rather than being sent to a community hospital emergency room for immediate treatment, as would have been appropriate, the patient was sent to the prison's Outpatient Housing Unit for observation. RT 348:7-12 (Goldenson). He died shortly thereafter from cardiac arrest. *Id.* Dr. Goldenson found that this course of treatment was "the most reckless and grossly negligent behavior [he had] ever seen by a physician." RT 350:21-24; Ex. 80 at 4 (10/09/04 Investigation into Patient Death).

19. In another example, a prisoner repeatedly requested to see a doctor regarding acute abdominal and chest pains; the triage nurse canceled the medical appointment, thinking the prisoner was faking illness. RT 63:10-20 (Puisis). When the prisoner requested transfer to another prison for treatment,

his doctor refused the request without conducting an examination. RT 63:21-24 (Puisis). A doctor did see the prisoner a few weeks later but refused to examine him because the prisoner had arrived with a self-diagnosis and the doctor found this unacceptable. RT 63:25-64:7 (Puisis); Ex. 54 at 1. The prisoner died two weeks [10] later. RT 64:11-12 (Puisis). Sixty-two grievances had been filed against that same physician, but when interviewed by the Court Expert, the physician advised that most of the prisoners she examined had no medical problems and were simply trying to take advantage of the medical care system. Ex. 54 at 1.

20. In a further example, in 2004 a San Quentin prisoner with hypertension, diabetes and renal failure was prescribed two different medications that actually served to exacerbate his renal failure. RT 64:13-19 (Puisis). An optometrist noted the patient's retinal bleeding due to very high blood pressure and referred him for immediate evaluation, but this evaluation never took place. RT 65:3-7 (Puisis). It was not until a year later that the patient's renal failure was recognized, at which point he was referred to a nephrologist on an urgent basis; he should have been seen by the specialist within 14 days but the consultation never happened and the patient died three months later. RT 64:22-65:4 (Puisis). Dr. Puisis testified that "it was like watching the natural history of high blood pressure turn into chronic renal failure somewhat similar to the Tuskegee experiment." RT 65:8-14 (Puisis).

21. Defendants have made some efforts to identify and remove from patient care those practitioners believed to be providing substandard care; in 2004, twelve such doctors were removed. RT 595:10-21

(Kanan). The Quality In Corrections Medical ("QICM") program, developed in conjunction with the Court Experts, Dr. Kanan, Dr. Shansky, and the University of California at San Diego ("UCSD"), seeks to evaluate the work of identified CDCR physicians in order to improve and assure physician quality. RT 606:25-609:6 (Kanan). However, QICM has encountered considerable obstacles to implementation and as of yet has not satisfactorily addressed the problems of incompetence and indifference. RT 539:7-13.

(I) Death Reviews

22. Death reviews provide a mechanism for medical delivery systems to identify and correct problems. RT 37:7-11 (Puisis); RT 367:10-17 (Goldenson). These reviews should determine whether there has been a gross deviation from the adequate provision of care and whether the death was preventable. RT 342:14-344:20 (Goldenson). These reviews should [11] be conducted even when death is expected, such as with a terminal condition, to determine if appropriate care has been provided. *Id.*; *see also* RT 587:2-7 (Kanan).

23. Expert review of prisoner deaths in the CDCR shows repeated gross departures from even minimal standards of care.[2] In 2004, the Court Experts and

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[2] As stated in the Stipulated Order, the Court applies a "community standard," i.e. the standard of care imposed under the laws of the State of California upon health care providers licensed to practice in California. *See* Stipulation for Injunctive Relief at 11 n. 3; *see also U.S. v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987) (defining constitutionally adequate medical services as being "at a level reasonably commensurate with modem medical science and of a quality acceptable within prudent professional standards"); *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990) (measuring standard of care under Eighth Amendment by "professional standards").

Dr. Shansky reviewed approximately 193 deaths, the majority from August 2003 to August 2004. These death reviews were the result of an Order of this Court after CDCR failed to perform the death reviews independently. RT 38:10-21 (Puisis); see also Ex. 34 (Report on death reviews conducted by Drs. Puisis, Goldenson, and Shansky in December 2004). These were only a portion of the backlogged death review cases. RT 38:22-24 and 195:12-17 (Puisis); see also 370:1-7 (Goldenson).

24. The Court Experts concluded, and the Court finds, that thirty-four of the deaths were serious and probably preventible. RT 42:21-24 (Puisis). CDCR sent these thirty-four cases to physicians at UCSD for review. RT 370:22-371:1 (Goldenson). On May 31, 2005, the UCSD physicians provided reviews for 23 cases. RT 356:10-13 and 371:10-14 (Goldenson). In twenty cases, the UCSD physicians found serious errors that contributed to death. RT 372:2-9 (Goldenson); *see also* Ex. 84 (UCSD Physician Assessment and Clinical Education Program Review of CDC Death Records). The conclusions of the UCSD physicians confirmed that the medical care provided by the prison medical staff prior to the inmates' deaths was well below even minimal standards of care. Ex. 84. The reviewing physicians used the following language to describe some of their conclusions: "a gross" departure from the standard of care (Ex. 84, Case A at 2); "standard of care definitely not met" (Ex. 84, Case D at 17); "a number of deviations" and "a severe systemic problem" (Ex. 84, Case F at 24); [12] "a gross departure" and "treatment far below the standard" (Ex. 84, Case I at 32); "the connections medical system failed the patient" and the inmate "died of what quite likely was a preventible process" (Ex. 84, Case K at 39 & 41); "an egregious deviation"

(Ex. 84, Case Q at 59; Case X at 85); "a fatal omission" and "a gross deviation" (Ex. 84, Case U at 74); "multiple gross deviations" (Ex. 84, Case W at 83). A Court Expert also testified: "You would not expect one death like this in a relatively large sized facility for years. As an example, if I took one of the most problematic deaths that we reviewed, I don't think I saw one of these in my entire 20 years" experience in managing prison facilities. RT 44:7-13 (Puisis); RT 350:18-351:4 (deaths were the result of the "most reckless and grossly negligent behavior" he has ever seen) (Goldenson).

25. The Court will provide just one of many examples to illustrate the problems revealed by the death reviews. An inmate arrived at 4:30 a.m. at the prison infirmary due to complaints of shortness of breath and tiredness. Ex. 84, Case W at 2-3. About a week prior, the inmate had reportedly been swollen all over with a blood pressure of 150/126 and a heart rate of 100. The night before his death the inmate had been brought to the infirmary for very similar complaints. *Id.* The following morning at 6:00 a.m., the nurse and physician determined that further care was unnecessary at that time and released the inmate from the infirmary. *Id.* On his return to the transport van, the inmate began staggering, went down on his hands and knees and went prone. *Id.* As the inmate was helped into the van, a medical provider told a correctional officer that the inmate "was fine and just needed sleep." *Id.* When the inmate arrived at his housing unit fifteen minutes later, he stumbled out of the van, went down on his hands and knees, then went prone and became unresponsive. *Id.* By 6:30 a.m., the inmate had no vital signs, and at 7:02 a.m. he was pronounced dead. *Id.* The UCSD physicians determined that there were "multiple gross devia-

tions from the standard of care" in this case, including an inadequate monitoring of the inmate's diabetes and hypertension in the years before his death, a lack of concern for high blood pressure readings in the days and weeks before his death, the lack of a personal physician's evaluation of the [13] inmate when he came to the infirmary, and the failure to diagnose or treat the congestive heart failure from which the inmate presumably died. Ex. 84, Case 22 at 3.

26. The Court Experts have made even further findings based on their reviews of additional death records beyond those sent to USD. In March 2005, a Court Expert reviewed the death files of ten prisoners at SATF prison and determined that at least seven deaths were preventible, and two more might have been preventible. Ex. 54 at 2. The Court Expert concluded that the care provided in most of the cases constituted medical incompetence. *Id.*

27. In February 2005, the Court Experts made similar conclusions regarding the review of ten deaths at San Quentin; most of the deaths had been preventible. Ex. 55 at 13. The Court adopts these uncontested expert findings regarding preventible deaths.

28. All of this information led Dr. Puisis to the uncontested conclusion, as referenced in the Introduction, that on average, every six to seven days one prisoner dies unnecessarily. RT 44:218, 86:8-13 (Puisis) ("based on estimates of deaths, there is probably one to two preventible deaths per site per year.").

(ii) Morbidity

29. The lack of adequate care in prisons also has resulted in a significant degree of morbidity to

inmate-patients. RT 86:7-13 (Puisis); 372:14-373:14 (Goldenson). Morbidity is defined as any significant injury, harm or medical complication that falls short of death. RT 31:15 (Puisis).

30. In one instance, a physician's cruelty may have caused a prisoner to suffer paralysis. RT 74:6-75:8 (Puisis). The prisoner arrived at the clinic after a fight and was unable to move his legs. *Id.* As the patient had sustained a neck injury, the medical staff should have immobilized his neck to prevent further injury. *Id.* When the patient failed to respond as the doctor stuck needles in his legs, the doctor said that the patient was faking, and moved his neck from side to side, paralyzing the patient, assuming he was not already paralyzed. *Id.*

Dr. Puisis termed his actions "fairly amazing" and cruel. *Id.*

[14] 31. In addition, the CDCR has a significant number of preventable acute care hospitalizations. RT 161:7-20 (Puisis). Due to the lack of appropriate care, the health of high risk chronic care patients is particularly compromised, and though such care may not lead to death, lives are markedly shortened. RT 372:14-373:2 (Goldenson). Considering the general risk to patients due to inadequate medical care, the unnecessary deaths are just "the tip of the iceberg." *Id.*

32. Given the Court's findings regarding inmate deaths, it should be no surprise that the Court also finds that there is an inordinately high level of morbidity among CDCR prisoners.

C. Nurses

33. The evidence establishes beyond a doubt that the CDCR fails to provide competent nurses to fill the needs of the prison medical care system. According to the Court's nursing Expert, Maddie LaMarre, CDCR nurses often fail to perform basic functions and refuse to carry out specific physician's orders. RT 279:16-280:6 (LaMarre). She also found that a number of nurses were not even certified in basic CPR. Ex. 53 at 10 (02/28/05 Expert LaMarre's Report on CS? - Sacramento from January 24-25, 2005). At certain prisons, nurses often fail to identify urgent medical issues that require immediate referral to a physician. RT 285:17-286:7 (LaMarre). Even where face-to-face triage is implemented, nurses often fail to take vital signs or conduct examinations. Ex. 56 at 4; RT 286:8-24 (LaMarre). Nurses then often fail to adequately assess patients and dispense appropriate over-the-counter medications for problems. RT 286:25-287:7 (LaMarre).

34. Additionally, the evidence shows that those nurses who fail to perform basic duties over an extended period of time are not disciplined. Ex. 62 at 10 (05/16/05 Experts' Report on Visit to Substance Abuse Treatment Center); RT 275:7-276:7 (LaMarre).

(3) Lack of Medical Supervision

35. The Court finds that the lack of supervision in the prisons is a major contributor to the crisis in CDCR medical delivery.

36. At the institutional level, there are very few managers and supervisors that are competent. RT 386:9-23. (Goldenson). Thus, it is difficult to carry out central office [15] directives. RT 94:5-8 (Puisis). Just five or six prisons have an adequate Chief Physician

and Surgeon, and only one-third of the prisons have an adequate Health Care Manager. RT 578:7-579:2 (Kanan). For example, the Experts report that San Quentin is "a completely broken system bereft of local medical leadership." Ex. 55 at 9.

37. A large part of the problem is simply a lack of personnel and a chronic high vacancy rate. Ex. 51 at 2 (02/18/05 Expert LaMarre's Report on Salinas Valley State Prison from January 26-27, 2005 Visit); Ex. 55 at 11; Ex. 60 at 1 (05/04/05 Email from Expert Puisis re: Experts' concerns from visit to Pleasant Valley State Prison). Many line-staff, including both physicians and nurses, work without any supervision whatsoever. Ex. 39 at 5 (01/03 OIG Management Audit Review from California Substance Abuse Treatment Facility and State Prison (and supplement to report), pages 5-7, 22-38, Attachment A); Ex. 62 at 4; Ex. 63 at 2 (05/16/05 Experts' Report on Visit to California State Prison - Corcoran); Ex. 64 at 6 (Experts' Report on Visit to Pleasant Valley State Prison Miscellaneous); Ex. 95 at 2 (Email from Dr. Puisis re: Conference Call re: CSP-SAC); RT 273:18-25 (LaMarre).

38. This lack of leadership and supervision has resulted in a failure to correct the myriad problems within the CDCR medical clinics. Ex. 51 at 2; RT 95:18-22 (Puisis). Such unaddressed problems have made the provision of adequate medical care impossible and clearly have resulted in patient deaths. Ex. 54 at I, 2; Ex. 62 at 5; RT 285:11-286:4 (LaMarre).

39. A further result of this non-supervision is that doctors responsible for patient death and morbidity receive little if any discipline from supervising physicians. RT 44:24-45:6 (Puisis). Beyond the obvious

problem of condoning malpractice and allowing incompetent doctors to remain on staff, the leadership vacuum and lack of discipline also fosters a culture of non-accountability and non-professionalism whereby "the acceptance of degrading and humiliating conditions [becomes] routine and permissible." Ex. 55 at 11; Ex. 51 at 2. No organization can function for long when such a culture festers within it, and it has become increasingly clear to the Court that this is a major factor in the current crisis.

[16] (4) Failure to Engage in Meaningful Peer Review

40. Peer review is the periodic review of work by similarly qualified professionals. Ex. 49 at 3; RT 136:5-7 (Puisis). For quality control and the identification of bad practitioners, peer review is performed universally by health care organizations. RT 136:8-10, 137:9-13. (Puisis). But in the CDCR, peer review "is either bogus or it's not done at all." RT 136:21- 23 (Puisis).

41. The peer review process sometimes fails because there is a paucity of qualified staff to engage in the process. Doctors with internal medicine qualifications are needed to review medical decisions, correct mistakes and provide training, but such doctors are rarely present at the institutions. Ex. 49 at 3-4. At some prisons, the doctors who engage in the peer review process are incompetent. As a result, "untrained physicians who make mistakes will continue to make them because there is no one to identify and correct their mistakes." *Id.*

(5) Defendants Lack the Capacity to Recruit Qualified Personnel for Key Medical Positions

42. The CDCR also suffers from a significant vacancy rate in critical positions within the medical care line-staff. Ex. 1 at 2 (01/09/04 Letter from QMAT Members re: San Quentin Visit on January 7, 2004); Ex. 2 at 4 (01/07/05 QMAT Process Review of San Quentin); Ex. 10 at 4 01/04 QMAP System Review of California Correctional Institute); Ex. 18 at 1 (08/25/04 QMAP Institutional Review Weekly Report from Salinas Valley State Prison); Ex. 23 at I (09/03/04 QMAP Institutional Review Weekly Report from California State Prison -Sacramento); Ex. 33 at 11 (Corrective Action Plan for July 9, 2004 Letter from Court Experts, Revised 03/03/05); Ex. 41 at 113; Ex. 48 at 6-7; Ex. 51 at 2; Ex. 56 at 11 ; Ex. 84 at 4. The vacancy rate for physician positions is over 15%, and this does not account for the additional significant percentage of incompetent doctors who need to be replaced. RT 579:11-13 (Kanan). The rates differ from institution to institution, depending partly on the desirability of the location and the culture of the prison. At one institution, there are only two doctors responsible for approximately 7,000 prisoners. RT 643:22-644:7 (Kanan).

[17] 43. The Court finds, based on estimates by the court Experts and CDCR's consultant, that the CDCR must hire approximately '150 competent physicians to fill vacancies and replace inadequate physicians throughout the system. RT 96:9-12 (Puisis); RT 680:19-23 (Shansky).

44. The vacancy problem also plagues the Department in all other areas of health care staffing. Vacancy rates at some institutions are as high as 80% for Registered Nurses (RNs) and 70% for Medi-

cal Technical Assistants (MTAs) (i.e. licensed vocational nurses who are also custody officers). RI 287:20-22 (LaMarre).

45. The CDCR has made some efforts to recruit and retain qualified supervisors, doctors, nurses and MTAs. However, these efforts have paled in the face of the enormity of need. RT 58:3-60:5(Puisis); RT 288:3-5 (LaMarre). The CDCR's efforts also have been stymied to large degree by the state bureaucracy, as discussed below.

46. The reality facing the CDCR is that its efforts to recruit qualified medical staff into the current system have been ill-fated from the start. For example, compensation levels for CDCR medical staff are simply too low. RT 59: 8-17 (Puisis) According to a CDCR commissioned study, compensation for CDCR staff registered nurses is 20-40% lower than for RNs in the private sector, and up to 57% lower for some supervising nurses. Ex. 81 at 8 and 11 (CDCR Nurses and Pharmacists Compensation Survey, November 2004). Yet the State has failed to pay heed to the study and the nurse staffing crisis continues unabated.

47. The difficulty in recruiting qualified medical staff is compounded by the poor working conditions offered. RT 295:21-24 (LaMarre). In one instance, the triage nurse at San Quentin had to walk through the men's shower room, while it was in use, in order to get to her "clinic" in which she had no sink, exam table or medical equipment. RT 295:1-12 (LaMarre). Many competent professionals simply will not work, at least not for long, under such conditions.

48. In addition, the long and bureaucratic hiring process at CDCR increases the difficulty of retaining

competent doctors and nurses. RI 99:21-25 (Puisis); RT 291:1 1-21(LaManie). The testimony at the hearing makes it clear that the State bureaucracy is simply incapable of recognizing and acting upon the crisis in which the CDCR finds itself.

[18] 49. In all fairness, the CDCR has made some progress lately, though it is far too limited relative to the enormity of the need. Since July 1, 2004, the Department has hired and retained approximately 27 additional board-certified or board-eligible family practitioners or internists and has contracted with two outside entities to provide additional care for high acuity patients to address shortages at various prisons. RT 580:8.-15; 588:16-589:9; RI 59.1:6-592:12 (Kanan), It also has intensified recruitment through the creation of a "physician strike team" that has conducted rounds at a local university and has established an interagency agreement with the University of California to have access to primary care residency programs. RT 604:2-15 (Kanan) In order to provide hiring incentives to qualified physicians, the CDCR has expanded the federal loan repayment program. RT 603:19-21 (Kanan). Although these improvements facilitate recruitment, they are piecemeal steps that fail to make the necessary transformations in the system; thus, they are insufficient to resolve the crisis. Consequently, the Court finds that vacancy rates in CDCR medical staff remain at a critical level.

(6) Intake Screening and Treatment

50. At present, the reception center intake process, which involves only a brief medical examination, fails to adequately identify and treat the health care problems of new prisoners. RT 301:18-24 (LaMarre); RT 116:16-117:8, 120:5-10 (Puisis). This

intake process is supposed to allow medical staff to identify the medical problems, in particular communicable diseases such as syphilis and tuberculosis, that pose a risk of transmission to other prisoners. RT 119:22-120:4 (Puisis); RT 301:2-12, 305:47 (LaMarre). In fact, tuberculosis is an "incredibly serious problem" in the prisons because it has the potential to affect other prisoners, the staff and the local community. RT 361:20-362:2 (Goldenson).

51. An adequate intake exam should take fifteen to twenty minutes for a young healthy prisoner and thirty to forty minutes for prisoners with more complicated health problems. RI 308:8-14 (LaMarre). However, prisoners' exams in CDCR reception centers typically last no more than seven minutes. RT 119:11-18 (Puisis). Further, some prisoners are [19] removed from the reception process before their examination is complete and do not receive medical screening or care until weeks later. RT 304:234305:18 (LaMarre).

52. For example, at Sari Quentin one to two physicians are responsible for conducting intake examinations of approximately eighty to one hundred new prisoners every day. The volume of work is too large to allow for adequate screening of illnesses. Ex. 55 at 7. The Court personally toured San Quentin and has first-hand knowledge of the shocking inadequacy of the reception screening process. The lack of sanitation, the dearth of basic medical examination toots, and the failure to provide any semblance of confidentiality in the medical examining rooms were apparent at first glance.

53. At the California Institution for Men (OM), which the Court also personally visited, a single nurse individually interviews 100 to 180 incoming

prisoners each day within a period of approximately four hours, allowing just a few minutes for each prisoner. RI I 16:22 I 17:2 (Puisis). In addition, a fellow prisoner completes the TB screening form for incoming prisoners (RT 302:7-11 (LaMarre)), which is an improper violation of medical confidentiality and harkens to the discredited and foregone practice in Southern prisons where so-called prisoner "trustees" were used to guard other prisoners. Following the nurse's examination, prisoners undergo an examination by a physician at which up to three prisoners are interviewed and examined simultaneously with no individual protection of the prisoners' privacy. RT 117:22-118:11 (Puisis). According to a Court Expert, this lack of privacy "virtually ensures that an adequate exam would not be done." RT 118:12-13 (Puisis). In fact, in some cases, serious conditions are not identified or are given no treatment. RT 306:10-22 (LaMarre) (prisoner with cirrhosis and swelling ankles was identified at screening but was provided no treatment or follow-up; three days later, he collapsed in the cell block and required transfer to an acute care hospital).

(7) Patients' Access to Medical Care

54. As a matter of medical policy, the CDCR requires that within one business day of the submission of a prisoner request for medical care, an RN shall triage the request using an in-person interview and standardized protocols. Inmate Medical Services Policy ("IMSP") Vol. [20] 4, Chp. & Vol. 5.[3] Unfortunately, this policy lives more on paper than in reality. The CDCR has left several basic nursing policy

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[3] The Inmate Medical Policies and Procedures were lodged with this Court on February 15, 2002.

requirements only partially implemented and at some prisons face-to-face triage is nonfunctional. RT 268:1-7 (LaMarre); see also Ex. 4 at 1 (12/22/04 Email from Lilia Meyer re: Monthly Reports); Ex. 5 at 1 (QMAT Executive Summary of Medical Services Clinical Indicator Review of Corcoran from June 21-25, 2004 Visit); Ex. 15 at 2 (04/01/04 QMAT Executive Summary of Medical Services Process Review at Salinas Valley State Prison); Ex. 51 at 11; Ex. 53 at 8; Ex. 62 at 8; and Ex. 63 at 67. As a result, patients do not receive timely access to care and suffer a serious risk of harm and even death as a result. RT 267:5-268:7 (LaMarre).

55. In addition, inmates do not have timely access to physicians. Appointments with physicians often do not take place within the time frame established by CDCR policy. Ex. 13 at 5 (QMAT Executive Summary of Medical Services Clinical Indicator Review of Valley State Prison for Women from June 21-24, 2004 Visit); Ex. 15 at 2; Ex. 25 at 6 (QMAT Executive Summary of Medical Services Clinical Indicator Review of High Desert State Prison from May 10-14, 2004 Visit); Ex. 39 at 24; Ex. 51 at 11. A number of prisons experience "serious backlogs in patients receiving medical care." Ex. 62 at 5; Ex. 64 at 2.

(8) Medical Records

56. The medical records in most CDCR prisons are either in a shambles or non-existent. RT 109:18-23 (Puisis). This makes even mediocre medical care impossible. Medical records are an essential component of providing adequate patient care and should contain comprehensive information about a patient that can assist a physician in determining the patient's history and future treatment. RT 109:5-17 (Puisis).

57. The amount of unified, disorganized, and literally unusable medical records paperwork at some prisons is staggering. RT 109:23.410:6 (Puisis); *see also* Ex. 2 at 4 (three and one-half feet of loose filing at San Quentin in December 2004); Ex. 20 at 3 (QMAT [21] Report from SVSP Institutional Visit for January 4-6, 2005)(twelve to eighteen inches of loose filing at Salinas Valley in January 2005); and Ex. 53 at 10 (six to eight feet of loose filing at CSP-Sacramento in January 2005). At CIM, the records were kept in a 30 foot long trailer with no light except for a small hole cut into the roof and were arranged into piles without any apparent order. RT 126:4-127:3 (Puisis). Conditions are similar at other prisons as well. RT 127:20-21 (Puisis). At some prisons medical records are completely lost or are unavailable in emergency situations. RT t11:4-112.6 (Puisis).

58. At CIM, the use of temporary medical records creates a confusing and dangerous situation for practicing physicians who often have access only to little or none of a patient's history. RT 114:2-115:11 (Puisis). The Court observed first-hand at CIM that doctors were forced to continually open new files on patients simply because the doctors could not get access to the permanent files. As a result, the risk of misdiagnosis, mistreatment, and at a minimum, wasted time, increase unnecessarily.

59. The Court concurs with Dr. Puisis's testimony that the CDCR medical records system is "broken" and results in dangerous mistakes, delay in patient care, and severe harm. RT 110:7-8; RT 112:8-22 (Puisis).

(9) Medical Facilities

60. The physical conditions in many CDCR clinics are completely inadequate for the provision of medical care. Ex. 1 at 2; Ex. 2 at 8; Ex. 60 at 1. Many clinics do not meet basic sanitation standards. Ex. 3 at 7 (04/22/05 Health Care Services, Quality Improvement Plan for San Quentin); Ex. 51 at 2; Ex. 53 at 7; Ex. 55 at 8 and 10; Ex. 58 at 2 (03/02/05 Email from Expert LaMarre re: Two Systemwide Issues); Ex. 62 at 9; Ex. 63 at 6; RT 296:23-298:9 (LaMarre). Exam tables and counter tops, where prisoners with infections such as Methicillin-Resistant Staph Aureus (MRSA) and other communicable diseases are treated, are not routinely disinfected or sanitized. RT 297:2-13 (LaMarre). Many medical facilities require fundamental repairs, installation of adequate lighting and such basic sanitary facilities as sinks for hand-washing. Ex. 62 at 11; Ex. 63 at 8. In fact, lack of adequate hygiene has [22] forced the closure of some operating rooms. Ex. 94 at 10 (Report on CDCR Hospitals and Skilled Nursing Care, October 9, 2004).

61. In addition, many of the facilities lack the necessary medical equipment to conduct routine examinations and to respond to emergencies. Ex. 1 at 2; Ex. 3 at 29; Ex. 10 at 1; Ex. 23 at 1; Ex. 33 at 4; Ex. 40 at 51 (03/16/05 Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institute for Men, pages 7, 49-63, Governor's Office and Related Materials); Ex. 48 at 3; Ex. 51 at 2 (02/18/05 Expert LaMarre's Report on Salinas Valley State Prison from January 26-27, 2005 Visit); E).. 55 at 5; Ex. 58 at 1; Ex. 62 at 9; Ex. 94 at 10; RT 128:15-25 (Puisis); RT 295:4-12 (La Marre). Clinics lack examination

tables and physicians often have to examine patients who must sit in chairs or stand in cages. Ex. 48 at 3.

62. The Court observed first-hand at San Quentin that even the most simple and basic elements of a minimally adequate medical system were obviously lacking. For example, the main medical examining room lacked any means of sanitation - there was no sink and no alcohol gel - where roughly one hundred men per day undergo medical screening, and the Court observed that the dentist neither washed his hands nor changed his gloves after treating patients into whose mouths he had placed his hands.

(10) Interference by Custodial Staff with Medical Care

63. A major problem stemming from a lack of leadership and a prison culture that devalues the lives of its wards is that custody staff present a determined and persistent impediment to the delivery of even the most basic aspects of medical care. Too frequently medical care decisions are preempted by custodial staff who have been given improper managerial responsibility over medical decision-making. Ex. 60 at 1; Ex. 64 at 4; RT 162:18-23 (Puisis).

64. Correctional officers often are not available to take prisoners to medical appointments or to enable the physicians to do examinations. Ex. 94 at 10. In medical units that lack call buttons for prisoners to contact doctors, custody staff routinely fail to make rounds and check on patients. Ex. 61 at I (05/06/05 Email from expert Goldenson re: San Quentin OHU); Ex. [23] 22 at 5 (QMAT Executive Summary of Medical Services Clinical Indicator Review of California State Prison – Sacramento from May 24-28, 2004 Visit).

65. All in all, there is a common lack of respect by custody staff for medical staff, and custody staff far too often actively interfere with the provision of medical care, often for reasons that appear to have little or nothing to do with legitimate custody concerns. Ex. 66 at 3 (02/18/05 and 04/26/05 Letters from Dr. Khoo to Chief Physician and Surgeon Dr. Williams re: issues with Medical Staff at San Quentin). Ex. 51 at 2. This exacerbates the problem of physician retention, and the evidence reflects that a number of competent physicians have left CDCR specifically due to conflicts with custodial staff. Ex. 84 at 4; RT 98:19-23 (Puisis).

(11) Medication Administration

66. The Court concurs with Dr. Puisis that management of the prison pharmacy operations is "unbelievably poor." RT 160:13-14 (Puisis). There is no statewide coordination between pharmacies and there is no statewide pharmacist. RI 236; 2-6 (Puisis). At the individual institutions, the administration of medications is in various states of disarray. RT 160:14-17 (Puisis).

67. The CDCR has failed to adequately implement the Inmate Medical Policies and Procedures that require each prison to develop local procedures for medication management. MOP, Vol. 4, Chp. 11 at 1; RT 283:2-10 (LaMarre).

68. There are serious, long-standing problems with dispensing medication, renewing prescriptions, and tracking expired prescriptions. *Id.* Chronically ill patients are not able to refill their prescriptions in a timely manner. RT 283:20-25 (LaMarre); Ex. 15 at 3; Ex. 16 at 4 (04/01/04 QMAT Executive Summary of Medical Services Clinical Indicator Review of Salinas

Valley State Prison from June 7-10, 2004 Visit); Ex. 25 at 4; Ex. 51 at 15-16; Ex. 55 at 51; Ex. 63 at 16; Ex. 64 at 49; Ex. 84 at 9.

69. The Court observed the pharmacy at San Quentin first-hand. As discussed in the Order to Show Cause, the pharmacy was in almost complete disarray. Additionally, there is no system to identify expiring prescriptions for critical medications and patients wait two to [24] three weeks for refills, which places many inmates at unnecessarily increased risk. Ex. 84 at 9.

70. To ensure continuity of treatment, the policies require that prescriptions continue to be filled when a prisoner transfers to another prison. IMPP, Vol. 4, Chp. 11 at 7. In practice, however, the prisons do not consistently transfer prescriptions along with the inmates, resulting in large quantities of medication being thrown out rather than administered. Ex. 22 at 4; Ex. 39 at 36; Ex. 51 at 9; Ex. 84 at 9. On the other end, the receiving prisons routinely disregard prescriptions from sending prisons. Ex. 26 at 3 (Report from March 22-25, 2004 Assessment of High Desert State Prison, written by Suzette Geary, Jerry Misery, and Any Perez); Ex. 27 at 2(QMAT Executive Summary of Medical Services Process Review of California Institution for Women from March 22-24, 2004 Visit); Ex. 64 at 12.

(12) Chronic Care

71. A sizable portion of CDCR prisoners suffer from chronic illness, yet defendants have failed to devise and implement a system to track and treat these patients, and such patients suffer from a lack of continuity of care. RT 90:15-20 (Puisis); RT 284:15-19 (LaMarre); Ex. 10 at 3; Ex. 18 at 1; Ex. 53 at 4; Ex. 61

at 1-2; Ex. 63 at 14; Ex. 64 at I I; Ex. 84 at 4; RT 284:20-285:1 (LaMarre)

(13) Specialty Services

72. Defendants have failed to provide patients with necessary specialty services. Patients with very serious medical problems often wait extended periods of time before they are able to see a specialist due to unnecessary and preventable delays. Ex. 60 at 2; Ex. 64 at 9 and 53; RT 312:5-15 (LaMarre). At Pleasant Valley State Prison ("PVSP") for example, it may take over a year to see certain specialists; as of May 2005, patients with consultation referrals from early 2004 had yet to be seen. Ex. 64 at 9-10; RT 313:3-12 (LaMarre). In one instance a patient with a colonoscopy referral had to wait ten months before his appointment; by the time he was seen the mass in his colon was so large that the colonoscopy could not pass through. *Id.* at 9-10. Even when patients do see a specialty consultant, medical staff often do not follow-up on the specialist's recommendations. Ex. 64 at 10.

[25] (14) Medical Investigations

73. The CDCR's failure to perform adequate investigation of medical staff results in incompetent and abusive staff continuing to provide dangerous care. Ex. 85 (Category 11 Investigations dated May 5, 2005-Filed Under Seal); RT 582:24-583:24 (Kanan). Too often, medical investigations have been ineffective because of coverups. For example, when a CSP-Sacramento inmate died, a CDCR central office physician evaluated the prison physician's conduct through an Internal Affairs investigation. Ex. 80 (10/09/04 Investigation into Patient Death); RT 345:23-349:22 (Goldenson). The central office reviewing physician concluded that the patient was

totally mismanaged and that the death was preventable. Ex. 8Oat 4-5; RT 348:13-20 (Goldenson). Subsequently, a second central office physician reviewed the case and determined that care was adequate. Ex. 80; RT 348:13-349:13. Although this second report was superficial and totally inadequate, the CDCR accepted it, clearing the prison physician and disregarding the thorough findings of the earlier review. Ex, 80 at 5. Dr. Goldenson described this as a "cover up of a very serious medical error." RT 349:21 (Goldenson). The prison doctor continued to practice for more than a year. RI 349:14-18 (Goldenson).

(15) Defendants Have Been Unable to Overcome Various Obstacles to Providing Adequate Medical Care

74. The Court recognizes that certain obstacles external to the CDCR have hindered the Department's ability to effectively take action regarding medical care. RT 549:5-551:4 (Carruth); RT 671:23-672:23 (Shansky). These obstacles are presented by the State of California's civil service system and the related operations of the State Personnel Board ("SFS"), the Department of Personnel Administration ("DPA"), the State budget process, and the collective bargaining obligations of the CDCR with respect to its union-represented employee groups. RT 551:5-25 (Carruth). However, these obstacles do not in any manner excuse defendants, including the Governor, from taking effective action to cure constitutional violations.

[26] a. Civil Service Obligations

75. Certain State civil service rules, grounded in the California Constitution and other laws and regulations, place the authority over creating new job

classifications, hiring, setting compensation levels, and creating recruitment and retention bonuses within the authority of the State Personnel Board, the Department of Personnel Administration and other agencies, thus preventing CDCR from acting unilaterally in these areas. RT 454:15-455:9, 465:19-466:13 (Duveneck). These requirements have directly affected the CDCR's ability to hire and recruit, because when the CDCR attempts to create new job classifications, or change the salary for an existing position, it generally must endure a lengthy process involving the DPA, SPB and the applicable bargaining unit representatives. RT 469:3-476:15, 479:23-480:24 (Duveneck).

b. The Dills Act

76. Under the Dills Act (Government Code § 3512 *et seq.*,), employees have the right to collectively bargain with the State over wages, hours, and other terms and conditions of employment. RT 426:15-23 (Hanson). The State has interpreted coverage of the Dills Act to extend to virtually any change in the terms or conditions of employment, including changing the way an employee is required to fill out a form. RT 428:1-11 (Hanson); RT 426:25-427:4, 427:13-25, 428:1-11 (Hanson); Cal. Govt. Code § 3512 et seq.

c. Procurement, Contracting, and Budgeting Rules

77. In general, the California Department of General Services must approve all State contracts, including contracts for personal services and contracts for information technology goods and services. Cal. Pub. Cont. Code §§ 10295, 10335-10381, 12102. Deputy Secretary for Information Technology for CDCR, Jeff Baldo, testified that the entire

contracting process, from the initial stage of determining the need for goods or services for information technology to awarding a contract, can take up to two years. RT 493:9-18 (Baldo).

78. The State budgetary process similarly hinders defendants from instituting medical reforms. There is a lengthy process for obtaining resources for personnel, equipment or [27] facilities. It generally takes between 14 months to two years for a budget concept to result in an appropriation of funds. RT 527:15-18 Morel). An even lengthier capital outlay process must be used when the CDCR seeks to build a new building or make significant changes to an existing structure. RT 527:20-528:6 (Hormel).

79. Thus, the Court recognizes that reforming the CDCR medical system is neither simple nor easy. However, the question is whether defendants have used the full extent of their power to raise the system to constitutional standards, and the answer is quite definitively: no. Perhaps no better illustration epitomizes the problem than the following colloquy that occurred during the CSC hearing between the Court and one of the State's Deputy Secretary for Human Resources as to why defendants have been so stymied by the bureaucracy. RT 457:2-458:17 (Duveneck). The Deputy Secretary testified that the State "cannot contract out for [medical] services unless it's an emergency, if State workers could do the work." RT 456:4-6 (Duveneck). When asked for an example of an emergency that had justified contracting out in the past, the witness testified that an agency received emergency approval to hire contractors when immediate hiring was a prerequisite to receiving federal funds. RT 457:14-21 (Duveneck). The Court responded that in one to six months "we would have 3 to 18

people dying . . . I can't think of a bigger emergency." RT 457:22-458:4 (Duveneck). Even in light of the Court's concern, the witness continued to balk at the idea of doing any emergency contracting whatsoever for prisoner medical services. RT 458:4-15 (Duveneck). This is exactly the kind of "can't do" attitude (or "trained incapacity," as discussed below) that has left the Court utterly frustrated and that has brought the Court to the point of establishing a Receivership.

C. Defendants Have Failed to Comply with Court Orders

The Court has attempted to move defendants toward meeting constitutional standards by issuing a series of court orders with detailed objectives and measures. Unfortunately, defendants have repeatedly delayed their progress and ultimately failed to achieve even a semblance of compliance.

[28] (1) The June 13, 2002 Stipulation for Injunctive Relief

80. Defendants entered into a Stipulation for Injunctive Relief which required CDCR to implement specified remedial medical policies and procedures designed to meet "the minimum level of care necessary to fulfill the Defendants' obligation to Plaintiffs under the Eighth Amendment of the Constitution." Stipulation for Injunctive Relief at 2-3.

a. Roll-Out Implementation

81. The Stipulated Injunction required the CDCR to implement the specified remedial medical policies and procedures at all California state prisons according to a staggered schedule beginning in calendar year 2003. Stipulation for Injunctive Relief at 3-4.

The first "roll-out" institutions were given a calendar year to implement the requisite policies and procedures. *Id.* As of this date, no prison has implemented them. RT 34:2-19 (Puisis); RT 267:15-25 (LaMarre); RT 341:17-24 (Goldenson); RT 666:3-7 (Shansky).

82. In fact, the roll-out institutions are not even close to attaining compliance. RT 666:5-7 (Shansky). Specifically, the Court Experts' review of San Quentin found that "overall compliance with the Stipulated Order and subsequent Court Orders was non-existent." Ex. 48 at 3. A May 2005 Expert review of PVSP (a 2004 roll-out prison) found it "substantially non-compliant." Ex 64 at 2. Fifteen months after the roll-out started, QMAT reported that Valley State Prison for Women ("VSPW") had not met six of eight indicators for overall compliance. Ex. 12 at 1.

83. Defendants rightly concede that they have not complied with the Court's Order. Defendants' Response to Order to Show Cause (filed June 20, 2005) at 2, 6. Moreover, Dr. Shansky testified that there "isn't a realistic possibility of compliance with the court orders . . . unless something dramatically changes." RT 666:13-25 (Shansky); RT 550:12-19 (Carruth).

b. January 1, 2003 Measures for all Institutions

84. in addition to the phase-in of the medical policies and procedures discussed above, the Stipulated Injunction also required the CDCR to implement five particular policies or procedures considered crucial to meeting class members' basic needs at all prisons statewide, [29] effective January 1, 2003. Stipulation for Injunctive Relief at 4. For instance, the Stipulation mandated that, effective January 1, 2003, all

prisons follow the medical protocol established for inter-institution transfers. *Id.* Defendants have not met this requirement. Ex. 148 at 1-2; Ex. 51 at 4; Ex. 89 at 7 (Report by the Plata Medical Experts: Review of Progress of Inmate Medical Services Program Implementations at California State Prison, San Quentin, June 1, 2005); Ex. 51 at 4. Nor have they fully executed the other four requirements.

c. Death Reviews

85. As discussed above, the Stipulated Order required defendants to formulate "a minimally adequate death review process." Stipulation for Injunctive Relief at H. Although defendants have had over three years to comply, they have failed to establish an adequate death review system, and many of the unreviewed deaths present serious problems, including neglect and cruelty. RT 367: 18-21 (Goldenson); Ex. 36 at 18-24 (03/03 OIG Management Audit Review from California State Prison, Solano, pages 3-6, 11-14, 18-22, 28-30); Ex 54 at 2; Ex 55 at 16-17; Ex. 57 at 1-3 (04/22/05 Expert Goldenson's Report of Dr. Wu). The CDCR has a backlog of over 300 deaths that have not been reviewed. RT 585:9-586:10 (Kanan). In addition, almost all the deaths that occurred (at an approximate rate of one per day) in March, April and May of this year have not been reviewed. *Id.*

d. Hiring Procedures

86. The Stipulated Order mandated that "Prior to Calendar Year 2003, CDCR shall initiate appropriate hiring procedures to hire medical staff for employment beginning January 1st." Stipulation for Injunctive Relief at 4. The CDCR failed miserably in meeting this requirement. Ex. 49 at 2. Unfortunately, low

standards in the hiring process have continued to plague the CDCR in recent times as well, with physicians being hired without primary care qualifications, with no background checks or primary care credential assessments, and with questionable practice histories. RT 669:4-17 (Shansky); RT 51:2-8 (Puisis). Dr. Puisis testified that the hiring procedures in California are "really the worst I have ever seen in my Life . . This is absolutely the worst." RT 100:25-101:2 (Puisis).

[30] 87. New screening procedures that have been implemented very recently, while an improvement, are inadequate, and require further steps to ensure that physicians are qualified to provide care to inmate patients. Ex. 49 at 4-5.

(2) 2004 Patient Care Order

88. In the Fall of 2004, it became apparent that further measures were required in light of the paltry progress that had been made to date. To this end, defendants stipulated to entry of the Patient Care Order.

This order required defendants to: (a) engage an independent entity to undertake measures with respect to the treatment of high risk patients; (b) evaluate the competency of physicians employed by the CDCR and provide training to those found to be deficient; (c) develop proposals regarding physicians, nursing classifications, and supervision; and (d) fund and fill Quality Management Assistance Teams (QMAT) and other support positions. *Id.*

Defendants have failed to meet the terms of the Patient Care Order.

a. High Risk Patient Care

89. Under the Patient Care Order, the CDCR has the duty to identify "high risk patients" whose medical condition makes them more vulnerable to death or serious injury than other patients. Patient Care Order at 3-4; RT 67:18-25 (Puisis). However, only roughly one quarter of those patients with complex medical problems are actually classified as high-risk. RT 87:25-88:23 (Puisis). High-risk patients should be treated by specialists, but instead are often treated by minimally qualified and incompetent doctors. RT 89:3-9 (Puisis). Furthermore, the plain fact is that the CDCR simply does not have enough qualified doctors to treat high-risk patients. RT 66:20-24 (Puisis). Although the CDCR does work with University of California system internists to provide medical care to high-risk patients, these sporadic consultations are inadequate to address the vastness of the problem. RT 54:21-55:2, 72:7-13 (Puisis).

b. Quality in Corrections Medicine ("QICM") Evaluations

90. The Patient Care Order required Defendants to complete evaluations of its physicians, and, if appropriate, to provide training for all physicians with clinical responsibilities at the [31] calendar year 2003-2004 roll-out institutions by December 31, 2005. Patient Care Order at 2. In cooperation with UC San Diego Medical Center, defendants created the Quality in Corrections Medicine (QICM) evaluation program. RT 432:18-21 (Hanson).

91. The CDCR has failed to make reasonable progress towards putting the QICM program into practice. It was not until a week after the OSC hear-

ing that clinicians began reporting for their evaluations. Kanan Decal. at 2.

c. Credentialing Policy

92. The CDCR's high number of incompetent or unqualified doctors is due in part to defendants' failure to track physician credentials and to remain cognizant of the areas of practice in which their board-certified doctors are certified. RT 51:20-25 (Puisis). The Patient Care Order required CDCR to establish a policy of credentialing and privileging physicians as a critical step to preventing harm to prisoners. RI 79:11-14 (Puisis).

93. Defendants were allotted five and a half months to institute a credentialing policy. Patient Care Order at 5. Credentialing is widely used in the health care industry, and the policies are "not that complicated." RT 79:21-23, 80:4-8 (Puisis); RT 645:3-6 (Kanan). Instead of developing this policy in house, the CDCR contracted out the task, waiting nine months to even sign a contract with the firm performing the work. RT 645:7-22. (Kanan).

94. At the beginning of 2005, the CDCR implemented a policy that forbade hiring independent contractors and primary care physicians who were not board-certified or board- eligible in internal medicine or family practice. Ex. 32 at I (Corrective Action Plan for Stipulated Court Order re: Quality of Patient Care and Staffing, Version updated 2/17/05); Patient Care Order at 3. The central office now investigates each new CDCR physician by doing a broad search of practitioner databases to ascertain whether other health care entities have reported adverse credentialing actions regarding them or malpractice settlements on their behalf that are indicative of problems

with their patient care. RT 597:11-600:.1 (Kanan). However, the CDCR has not formally adopted this or any other credentials policy, which is evidence of a lack of will (or at a minimum a lack of competence) for systemic reform in this area. RI 79:15-20 (Puisis). Due to the lack of a credentialing policy, [32] many CDCR doctors are not qualified to practice the type of medicine required by their position and practice outside their area of medical expertise. Ex. 40 at 52-53; Ex. 49. For example, within the CDCR, one OBGYN manages HIV patients and an incompetent neurosurgeon practices internal medicine. Ex. 49 at 3.[4]

CONCLUSIONS OF LAW

I. The Establishment of a Receivership is Warranted

A. Historical Background of Receivership Remedy

The receivership remedy has its roots in the English Chancery Courts, where receivers were appointed to protect real property and monetary rents and profits. *See* Ralph Ewing Clark, A Treatise on the Law and Practice of Receivers (3d ed. 1959) ("Treatise On Receivers"), citing Barnardiston's Reports (1740-1741) 69, 27 Eng. Rep. 558; *Gordon v. Washington*, 295 U.S. 30, 37 (1935). The traditional definition of a receiver is as follows:

> A receiver . . . is a person who . . . becomes an officer of the court to receive, collect, care for,

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[4] Although the Court has attempted to avoid commingling findings of fact with conclusions of taw, any conclusions that are inadvertently labeled as findings (or vice versa) shall be considered "in [their] true light, regardless of the label that the . . . court may have placed on [them]." *Tri-Tron International v. Velto*, 525 F.2d 432, 435-36 (9th Cir.1975).

> administer, and dispose of the property or the fruits of the property of another or others brought under the orders of court by the institution of a proper action . . .

TREATISE ON RECEIVERS at 13, *citing Spring Valley W. Co. v. City and County of San Francisco*, 225 Fed. 728, 731 (1918), *aff'd* 246 U.S. 391 0914. Additionally, technically property placed by a court in the hands of a receiver is not in the possession of the receiver but in the possession of the court through such receiver as its officer." TREATISE ON RECEIVERS at 626; *Atlantic Trust Co. v. Chapman*, 208 U.S. 360, 371 (1907) (receiver is an officer of the court).

The receivership process became incorporated into early American jurisprudence, where it has established a long historical tradition as part of the federal courts' equity jurisdiction, arising from Article III, section 2 of the Constitution ("The judicial Power shall [33] extend to all Cases, in Law and Equity, arising under this Constitution . . ."). *See In re Reisenberg*, 208 U.S. 90 (1908) (upholding displacement of corporate management by court- appointed receiver); *Washington v. Washington State Commercial Passenger Fishing Vessel Assoc.*, 443 U.S. 658, 695 (1979) (holding that district court has power to "assum[e] direct supervisions" of state property "if state recalcitrance or state-law barriers should be continued," and that the court may "displace local enforcement of [the court's] orders if necessary to remedy the violations of federal law found by the court"); FED. R. CIV. P. 66 (providing district court with control over appointment and dismissal of receivers); 4 JOHN NORTON POMEROY, POMEROY'S EQUITY JURISPRUDENCE § 1330 *et seq*. (Spencer W. Symons ed., Bancroft-Whitney 5th ed. 1941).

While the historical roots of receivership lie in the protection of property and assets, and at times in the implementation of corporate reorganizations, its usage expanded during the' civil rights era. In the second decision in *Brown v. Board Education*, the Supreme Court invoked the chancery tradition by stating that "equity has been characterized by a practical flexibility in shaping its remedies and by a facility for adjusting and reconciling public and private needs." *Brown v. Bd. of Educ.*, 349 U.S. 294, 300 (1955). The Court further discussed a "period of transition" during which the district courts should maintain jurisdiction over desegregation cases to "consider the adequacy of any plans the defendants m4 propose . . . and to effectuate a transition to a racially nondiscriminatory school system," thus suggesting that federal courts might be called upon to engage in long-term institutional oversight. *Id.* at 300-01 (1955); *see also* Owen M. Fiss, *Foreword: The Forms of Justice*, 93 HARV. L. REV. I, 3 (1979) (the second *Brown* decision "delegated the reconstructive task to the lower federal judges. They, in turn, discovered what the task required and adjusted traditional procedural forms to meet the felt necessities."). Subsequent intense resistence to integration presented certain federal district and appellate courts with no realistic choice other than taking control of school districts through the imposition of receiverships. *See, e.g. Turner v. Goolsby*, 255 F.Supp. 724, 730 (S.D. Ga. 1966) (state superintendent [34] appointed receiver for county school system); *Morgan v. McDonough*, 540 F.2d 527, 533 (1' Cir. 1976) (approving temporary receivership of South Boston High School).

The use of receivers to reform public institutions has spread to analogous contexts in the civil rights arena, including prisons. *See, e.g., Newman v. State of Ala.*, 466 F.Supp. 628, 635-36 (1979) (appointing receiver for Alabama State Prisons, stating: "The extraordinary circumstances of this case dictate that the only alternative to non-compliance with the Courts orders is the appointment of a receiver for the Alabama prisons."); *Shaw v. Allen*, 771 F.Supp. 760, 762 (S.D. W.Va. 1990) ("Where more traditional remedies, such as contempt proceedings or injunctions, are inadequate under the circumstances, a court acting with its equitable powers is justified, particularly in aid of an outstanding injunction, in implementing less common remedies, such as a receivership, so as to achieve compliance with a constitutional mandate."); *Wayne County Jail Inmates v. Wayne County Chief Executive Officer*, 444 N.W.2d 549, 556 (Mich. App. 1989); *Inmates of D.C. Jail v. Jackson,* 158 F.3d 1357 (D.C. Cir. 1998)[5]

Thus, the remedy being imposed through this Order follows a long historical line of precedent where nothing short of receivership could protect the plaintiffs' interests and remedy the violation of their constitutional rights.

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[5] The appointment of receivers has extended to other areas as well, such as mental health and child-protection services. *See, e.g., Dixon v. Barry*, 967 F.Supp. 535 (D.D.C. 1997) (appointing receiver for Commission on Mental Health Services); *Gary W. v. Louisiana*, 1990 WL 17537, *17, *28-33 (E.D. La. 1990) (appointing receiver to oversee state children's services agencies where court's mandates were continually met with "a dismal record of non-compliance and management by crisis"); *Judge Rotenberg Educ. Cntr., Inc. v. Comm'r of the Dep't of Mental Retardation*, 677 N.E.2d 127 (1 997) (appointing receiver of state Department of Mental Retardation).

B. Legal Analysis

The decision whether to appoint a receiver is a function of the court's discretion in evaluating what is reasonable under the particular circumstances of the case. *See Dixon*, 967 F.Supp. at 550; 12 CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE & [35] PROCEDURE § 2983 (2005). As the case law concerning the receivership remedy for the reform of public institutions has developed over the past few decades, a multi-pronged test has developed to guide the trial courts in making this often difficult determination. The test includes the following elements, the first two of which are given predominant weight:

(1) Whether there is a grave and immediate threat or actuality of harm to plaintiffs;

(2) Whether the use of less extreme measures of remediation have been exhausted or prove futile;

(3) Whether continued insistence that compliance with the Court's orders would lead only to confrontation and delay;

(4) Whether there is a lack of leadership to turn the tide within a reasonable period of time;

(5) Whether there is bad faith;

(6) Whether resources are being wasted; and

(7) Whether a receiver is likely to provide a relatively quick and efficient remedy. *See Dixon*, 967 F.Supp. at 550; *District of Columbia v. Jerry M*, 738 A.2d 1206, 1213 (D.C. Ct. App. 1999) (reversing appointment of receiver based on trial court's consideration of only the single factor of defendant's historical failure to comply with court mandates); *Morgan*, 540 F.2d at 533 (appointing receiver as "the only

reasonable alternative to non-compliance with [the] court's plan"); 12 FEDERAL PRACTICE & PROCEDURE § 2983 (factors relevant to establishing requisite need for receivership include "imminent danger," inadequacy of available legal remedies, probability of harm to plaintiff, and possibility of irreparable injury).

The Court will review each of these factors in turn.

(1) Threat of Harm

As the Findings of Fact amply demonstrate, the treatment of prisoners in California constitutes a "gross and extreme departure from the standard of care." The Supreme Court's discussion of prisoner medical care in *Estelle v. Gamble* was prescient in regard to the current situation in California:

> [36] An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," the evils of most immediate concern to the drafters of the [Eighth] Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency . . .

Estelle v. Gamble, 429 U.S. 97, 103 (1976).

Nothing beyond the Findings recited above need be said to express the severity of the health crisis facing California prisoners. Indeed, the findings in this Order scarcely do justice to the actual harm experienced by thousands upon thousands of individuals in the California prison system. As Judge Justice stated twenty-five years ago when describing the Texas prison system:

> [I]t is impossible for a written opinion to convey the pernicious conditions and the pain and degradation which ordinary inmates suffer . . . [including] the physical suffering and wretched psychological stress which must be endured by those sick or injured who cannot obtain adequate medical care.

Ruiz v. Estelle, 503 F.Supp. 1265, 1390 (S.D. Tex. 1980).

Based on the Findings, removing defendants from control of the medical system and imposing a Receiver to radically transform it is the only viable means of saving lives and creating a stable and effective health care delivery system in the CDCR. *See, e.g., Dixon*, 967 F.Supp. 535, 554 ("There is no doubt that without severe action by the Court [in the appointment of a receiver] . . . suffering and loss of life will continue unabated"); *LaShawn A. v. Kelly*, 887 F.Supp. 297, 315 (D.D.C. 1995) ("While it is true that the defendants have made some progress in various areas, the . . . factual findings show the urgent need for a new, more fundamental approach to change."). Indeed, the suffering and deaths that have occurred since this Court's oral ruling on June 30, 2005 weigh most heavily on this Court's mind and conscience as it tries to move expeditiously through these complex proceedings.

(2) Least Intrusive Means

In fashioning an appropriate remedy, the Court must exercise restraint, using the least possible power adequate to the remediation of constitutional violations. *See, e.g., Missouri v. Jenkins*, 495 U.S. 33, 51 (1990) (before intruding on local authority, district court must [37] assure itself that no lesser alternatives are adequate to the task). However, the Court is not required to restrict its powers to those means that have proven inadequate, or that show no promise of being fruitful. Rather, as the Supreme Court has held, "federal courts are not reduced to issuing injunctions against state officers and hoping for compliance. Once issued, an injunction may be enforced." *Hutto v. Finney*, 437 U.S. 678, 690 (1979). The Ninth Circuit similarly has held that "where federal constitutional rights have been traduced, principles of restraint, including comity, separation of powers and pragmatic caution dissolve . . ." *Stone v. City and County of San Francisco*, 968 F.2d 850, 861 (9t) Cir. 1992).

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626(a)(1)(A), which governs this case, codifies the Court's authority to issue prospective relief that fully remedies constitutional violations, while mandating that the relief not be overly broad. The relevant Language of the PLRA is as follows:

> Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

18 U.S.C. § 3626(01)(4). The Second Circuit recently held that "the deference due prison administrators by courts is implicated primarily by questions relating to institutional security of a type not raised" in the context of health-related conditions. *Benjamin v. Fraser*, 343 F.3d 35, 52 (2nd Cir. 2003). Nevertheless, this Court is able to abide in full with the "needs-narrowness-intrusiveness" standard of the PLRA, so it need not address whether a lesser standard is applicable in this case.

a. Failure of the Court's Efforts to Use Lesser Intrusive Means

The task of mining the CDCR medical system is a complex and difficult one, specially given the number of prisoners, the breadth and depth of their medical needs, the special difficulties posed in a correctional setting, the number and geographic dispersion of the state's 33 prisons, the extreme state of overcrowding, and the failures of past [38] administrations to take medical care seriously. The provision of adequate medical care in this situation presents a classic example of a "polycentric" problem. As then Professor of Law and now Ninth Circuit Judge William Fletcher has explained:

> The concept of polycentricity may help to clarify the problems involved in trial court remedial discretion in institutional suits. Polycentricity is the property of a complex problem with a number of subsidiary problem "centers," each of which is related to the others, such that the solution to each depends on the solution to all the others. A classic metaphor for a polycentric problem is a spider web, in which the tension of the various strands is determined by the relationship among all the parts of the web, so that if one pulls on a

> single strand, the tension of the entire web is redistributed in a new and complex pattern.

William A. Fletcher, *The Discretionary Constitution: Institutional Remedies and Judicial Legitimacy*, 91 YALE L.J. 635, 645 (1982) (citation omitted) ("*Discretionary Constitution*"). As just one example of the interrelatedness of multiple problem centers, the Court notes that thei hiring of competent medical staff and the creation of a working medical records system are two pressing issues. Both tasks must be accomplished simultaneously. Good doctors and nurses cannot be recruited if they know that they will be forced to treat patients without adequate medical records. At the same time, qualified doctors and administrators must be brought on board to establish and maintain the medical records system. One cannot function well without the other, and each element of the solution requires "mutual spontaneous adjustment." *Discretionary Constitution* at 647.

But to say that a problem is polycentric is not to say that it is insoluble. As expressed above, steps toward resolving this crisis have been ordered by the Court. Additionally, the Court Experts, plaintiffs, and the Court itself have provided specific achievable measures and have made innumerable informal suggestions as to how defendants can move forward. The Court invited the parties during monthly status conferences to contribute ideas as to possible remedies, and the Court especially encouraged defendants to consider ways in which they could take the actions necessary to solve the medical care problems through measures within their own control, including use of the extraordinary powers of the Governor. The Court went to the length of requesting that defendants present it with a series of proposed orders so that the

Court could help empower them to overcome some of their bureaucratic hurdles on [39] their own. *See* Order Following April 2005 Status Conference (filed April 29, 2005) at 2. Defendants did not submit a single proposed order. Finally, the Court issued the Order to Show Cause, which stated that "with respect to the substantive remedy itself, the Court encourages all parties to think as creatively as possible, and the Court will remain open to all reasonable alternatives." OSC at 17. Even following issuance of the OSC – on the brink of possible contempt and the imposition of a Receivership – defendants were able to enact only very limited and piece-meal measures, with no prospect for system-wide reform or restructuring.

In spite of all these efforts by the Court, defendants have been unwilling or incapable of breaking out of a deeply entrenched bureaucratic mind-set, and have refused or been unable to take the steps necessary to prevent further needless loss of life and suffering among its wards. As just one example, defendants have recognized that they need an immediate infusion of clinical and administrative staff, yet they have taken no measures to overcome the substantial barriers posed by the state bureaucracy. The result is that requests for medical staff, or for an increase in salary to attract qualified staff, or even for a salary survey, have been met with the same delay and resistance as requests for far less urgent matters.

This mind-set is a classic example of what the sociologist Thorstein Veblen terms "trained incapacity." THORSTEIN VEBLEN, THE INSTINCT OF WORKMANSHIP AND THE STATE OF THE INDUSTRIAL ARTS 34748 (Macmillan 1914). State officials have become so inured to erecting barriers to problems that appear to threaten the bureaucracy (or that at least appear to require the bureaucracy to bend or flex) that the officials have trained themselves into a condition of becoming incapable of recognizing, and acting in response to, true crisis. *See, e.g.*, Gary W. 1990 WL 17537 at *32 ("In instances of justifying [receivership], the courts have typically found a lack of leadership that could be expected to improve conditions within a reasonable period of time, systemic deficiencies in administrative, organizational, and fiscal structures, institutional inertia, and similar indicia of bureaucratic morass.").

[40] b. The Lack of Alternative Effective Remedies

In its attempt to allow defendants to resolve this crisis, the Court has exhausted all reasonable means of compulsion. Nonetheless, for the sake of thoroughness, the Court will briefly discuss the avenues that conceivably remain short of Receivership. First, the Court could impose contempt sanctions. However, the Court does not view a contempt remedy as having a realistic likelihood of proving effective. Pursuing a contempt remedy would greatly extend the future life-span of the current dysfunctional system, thereby placing innumerable lives in grave danger, with no hope that the sanctions would produce a positive result due to the State's self-professed inability to cope with the magnitude and complexity of this crisis. Even if lack of will were overcome to some extent and the Court were to succeed in forting the hand of certain individual defendants, the Court believes that other impediments – not least of which are the bureaucratic barriers discussed above and the long-standing culture of medical neglect – would largely subvert the effort and the system would still fall short of constitutional adequacy. Contempt simply is not an appropriate remedy in the current circumstances. As the court stated in Gary W.:

> [D]efendants have not only shown no capacity to implement corrective plans previously submitted, but also that they either are no longer willing or able to even devise remedial programs to address the clearly identified barriers to compliance with the Orders of the Court . . . Given the history of this case, including the past efforts of this Court to facilitate, cajole, and even coerce compliance, the (remonstrated inability of defendants to comply substantially with this Court's previous Orders (despite many opportunities to do so), and the flawed organizational structure [of defendants', this Court concludes that an Order holding the defendants in contempt is not an adequate remedy . . . Much measures "promise only confrontation and delay."

Gary W., 1990 WL 17537 at *29-30 (citation omitted); *see also Wayne County*, 444 N.W.2d at 561 (affirming receivership of county jail system, stating: "[W]e do not feel contempt is an appropriate vehicle to remedy the panoply of noncompliance in this case . . . The trial court correctly reached the realization that contempt proceedings would never bring full implementation of its orders."); *Newman*, 466 F.Supp. at 635; *Morgan*, 540 F.2d at 533 (rather than instituting contempt proceedings or issuing further injunctions, which "were plainly not very promising, as they invited further confrontation and delay," a receivership was necessary "to get the job done.").

[41] The Court also could consider appointing a special master. However, given defendants' professed inability to take adequate measures to cure the

constitutional violations even with the extraordinary guidance of the Court Experts and the mandates of the Court's orders, this would be an exercise in futility. As the court held in *Newman*:

> The lack of any significant progress since the original hearings in this case strongly suggests that the appointment of monitors offers little, if any, hope of swift compliance. The extraordinary circumstances of this case dictate that the only alternative to non-compliance with the Court's orders is the appointment of a receiver.

Newman, 466 F.Supp. at 635.

Another conceivable remedy is that of sequestration, whereby the courts traditionally have coerced compliance by detaining defendants' property, or by quasi-sequestration where the courts limit or shut off defendants' access to funds. *See, e.g., United States v. City of Chicago*, 549 F.2d 415 (7th Cir. 1977) (affirming district court's suspension of distribution of general revenue sharing funds to Chicago as means of compelling city to end racial discrimination in police department). However, the effect of depriving the CDCR of funds that are desperately needed for medical care would not only be counterproductive, but would result in a perversion of the equities in this instance.

The Court also could consider either closing some institutions or ordering the release of some prisoners (perhaps those who are at highest risk of receiving inadequate medical care, or those who pose the least security risk as a means of general population reduction). Since these options would be more onerous to defendants than the establishment of a Receivership, the Court need not entertain them at this time. *See*

Shaw, 771 F.Supp. at 763 (receivership "is not as drastic and intrusive as the ultimate course of action this Court could, and may yet effectuate – that of ordering the jail closed."); Newman, 466 F.Supp. at 635 ("There is, of course, a more extreme alternative to a receivership . . . [i.e.] the closing of several prison facilities. in light of that alternative, the more reasonable and the more promising approach is the appointment of [a] receiver for the prison system.").[6]

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[6] *See also Grain v. Bordenkircher*, 376 S.E.2d 140, 142 (W.Va. 1988) (issuance of "rule to show cause" for the appointment of a receiver to oversee the funding and construction of a new prison, costing roughly $50 million, despite the court's recognition of the state's "great economic distress, stating that such appointment would be "clearly a lesser evil than . . . [the prisoners' release from the penitentiary because of unconstitutional conditions of confinement."); *Feliciano v. Colon*, 1990 WL 83321 at *10 (D. Puerto Rico 1990) (placing defendants on notice that their failure to cure contempt could subject them to "compensatory fines," "coercive fines," "accelerated award of good time to prisoners to reduce population density," and "the imposition of a receivership."); *Wayne County*, 444 N.W.2d at 561 ("The receivership remedy is far from the most intrusive action [the trial court] might have taken . . . He could have taken a different approach and closed the jail until the final judgment was fully implemented."); 18 U.S.C. § 3626(f)(3) (provision of PLRA governing prisoner release orders); MALCOLM M. FEELEY & EDWARD L. RUBIN, JUDICIAL POLICY MAKING AND THE MODERN STATE: HOW THE COURTS REFORMED AMERICA'S PRISONS 93 (Alfred Blumstein & David Farrington eds., Cambridge University Press 1998) ("JUDICIAL POLICY MAKING") (describing process in *Ruiz v. Estelle* litigation in Texas whereby the court ordered the release of a certain number of inmates whenever crowding reached a certain level, and the state legislature responded by enacting legislation to permit the prison authorities to select which inmates to release); *cf Morgan*, 540 F.2d at 534 (establishment of receivership over school was less onerous than closing school, and district court "demonstrated both restraint and wisdom in selecting the receivership option," which was

[42] Notably, defendants have proposed no alternative measures to resolve the crisis and have not opposed the appointment of a Receiver. *See* Defendants' Response to Order to Show Cause.

Thus, having exhausted all reasonable coercive measures at its disposal, yet finding itself unable and unwilling to sit idly by while people are needlessly dying, the Court believes it is obligated to take control of the prison medical system. As the court stated in *Gary W.*:

> [T]he responsibility of this Court is "clear and compelling: to use its broad and flexible equitable powers to implement a remedy that, while sensitive to the burdens that can result from a decree and the practical limitations involved, promises, '*realistically to work now*.'"

Gary W., 1990 WL 17537, *30, *quoting Green v. County School Bd.*, 391 U.S. 430, 439 (1968); *see also Swann v. Charlotte-Mecklenberg Bd. of Ed.*, 402 U.S. 1, 16 (1971) (the scope of relief must be determined by the nature of the violation); *Feliciano*, 1990 WL 83321 at *11 (less than four years following stipulation to increase the size of prison cells, the court concluded: "[T]his court of equity will not suffer a wrong of such constitutional magnitude . . . to go any longer without an adequate remedy," including a possible receivership). In essence, the time has now come when the number of options with any realistic chance of success has dwindled down to a single one – Receivership.

"not excessive but [rather] reasonably tailored to carrying out the court's responsibilities").

[43] (3) Continued Delay

It is resoundingly clear to the Court that continued insistence on defendants' compliance with Court orders would lead to nothing but further delay, as well as further needless death and morbidity. As discussed above, the State sees itself as incapable of handling this crisis, and no degree of support or coercion is likely to help. *See Newman*, 466 F.Supp. at 635 ("Time does not stand still, but the Board of Corrections and the Alabama Prison System have for six years. Their time has now run out. The Court can no longer brook non-compliance with the clear command of the Constitution, represented by the orders of the Court in this case."); *Gary W*, 1990 WL 17537 at *29-30 ("The time for 'all deliberate speed' is long passed").

(4) Leadership

While blame for the deplorable condition of prison medical care in the state can properly be attributed to multiple causes, there is a single root cause of this crisis: an historical lack of leadership, planning, and vision by the State's highest officials during a period of exponential growth of the prison population. *See, e.g., Newman*, 466 F.Supp. at 630 ("The theme running throughout the evidence is a lack of professional leadership."). These State officials have the ultimate responsibility to hire, train, supervise, and audit their own staff, and to provide sufficient resources, technology, and support for those staff members to ensure that instances of negligent care and malpractice are kept to a minimum and that the system operates at least at the level of constitutionally adequate care.

The past and current leaders of the prison system have failed to take the bold measures necessary to protect the lives of prisoners, to find solutions to the impediments posed by the State bureaucracy, and to make systemic improvements. Many of these measures, such as taking incompetent doctors out of patient care, hiring qualified new doctors and nurses, and providing a medical records system are neither obscure nor infeasible.

Perhaps no better illustration exists of the lack of leadership than Dr. Shansky's testimony regarding the State's failure to maintain, and to capitalize upon, improvements made in the medical delivery system at San Quentin years ago pursuant to the litigation in [44] *Marin v. Rushen*, C-80-0012 MHP (N.D. Cal. 1980). RT 698:2-699:11. The Court's firsthand observation of the depths to which that institution was allowed to sink in the aftermath of careful and productive judicial intervention in *Marin* has had a profound effect on this Court.

Defendants also have failed to take a strong leadership position in resolving a long-standing impediment to medical care, which is the over-prioritization of custody interests even in the face of pressing medical needs. The testimony is replete with stories of prisoners suffering from obvious illness and injuries who are blocked from receiving medical attention by custody staff. While the Court is cognizant of the legitimate special difficulties posed in dealing with an incarcerated population, these challenges fail to explain or justify the severe imbalance of priorities in this case. *See* Susan Sturm, *Resolving the Remedial Dilemma: Strategies of Judicial Intervention in Prisons*, 138 U. PA . L REV. 805, 818 (1990) (describing phenomenon of "goal displacement" in prison administration).

The numerous deaths and harm from medical misfeasance and neglect have been predictable consequences of what can best be described as a "non-system" of care in California's prisons. This is not mere hindsight; rather, it has been the foreseeable and unavoidable result of the State's failure to use the full extent of its powers to meet its constitutional obligations. *See, e.g., Palmigiano v. Garrahy*, 448 F.Supp. 659, 671(D. R.I. 1978 (governor's efforts did not constitute 'all reasonable steps' toward achieving compliance " and "none of the reasons offered for delay by defendants related to an inability to comply"); *Bracco v. Lackner*, 462 F.Supp. 436, 449 (ND. Cal. 1978), *quoting Welsch v. Likins*, 550 F.2d 1122, 1132 (8th Cir. 1977) ("The obligation of defendants to eliminate existing unconstitutionalities does not depend upon what the Legislature may do or upon what the Governor may do . . .").

In all fairness, the Court recognizes that the current administration inherited many of the: problems identified above from past administrations, which must bear much of the blame for building California's vast prison system without regard for inmate medical care. As the Court has stated in the past, the Governor has appointed, and the State has hired, a number of [45] dedicated individuals to tackle the difficult task of addressing the crisis in the delivery of health care in the CDCR. These leaders have been forthright in conceding their failures,[7] have not attempted to obstruct the Receivership process, and have shown good faith and even enthusiasm in discussions with the Court and plaintiffs' counsel about the prospect of working with a Receiver toward the goal of revamping, and perhaps redesigning, the prison medical delivery system.

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[7] As discussed in the Findings, Undersecretary Kevin Carruth testified that medical care is not a "core competency" of the State prison leadership. This concession is a double-edged sword. On the one hand, defendants have had the wisdom to

When appointing receivers, courts often remove the officials in charge of the entity responsible for the constitutional violations from power and place the receiver in their stead. *See, e.g., Newman*, 466 F.Supp. at 636 (relieving the Board of Corrections of all power and displacing the Board with a receiver); *Morgan,* 540 F.2d 527. As an expression of the Court's trust in the current State leadership, the Court will deviate from this practice and will not displace any State officials. This trust must continue to be earned. This Order shall serve as notice to the current leaders of the prison system and of the State that they must do everything in their power to work cooperatively with the Receiver, to create substantial reform in the executive branch (within CDCR and in all other relevant agencies), to seek legislative reform where necessary, and take all other necessary measures to eradicate the barriers that have led to the current crisis. While these changes will take some time, the Court expects to see continual progress toward these goals. Ultimately, these changes will be essential to the Court's decision to return control to the State.

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recognize and admit their failure, as opposed to many other individuals or institutions who in similar circumstances would pursue indefensible positions to the bitter end. On the other hand, as discussed below, it is an abdication of the public trust for these officials to throw up their hands in surrender, at least prior to exhausting all measures available to them.

(5) Bad Faith

The question of motive is complicated. As in any case dealing with a governmental institution, circumstances are dictated by a combination of individual effort (or lack thereof) and bureaucratic and political forces. *See* Fiss, *Foreword: The Forms of Justice* at 22 ("In [46] the structural context, there may be individual wrongdoers . . . [but] the target of the suit [is] on a social condition . . . and also on the bureaucratic dynamics that produce that condition. In a sense, a structural suit is an in rem proceeding where the res is the state bureaucracy."). The Court has discussed above a number of these forces, including the leadership vacuum and the trained incapacity of the bureaucracy. While lack of will thus is a key factor contributing to this crisis, the Court need not ascribe ill will to defendants as a predicate to appointing a Receiver, and the Court declines to do so.

(6) Wasted Resources

While the Court has not yet ordered a detailed accounting, all the evidence supports the Court's firm conviction that defendants have engaged in a huge waste of the taxpayer's resources. Certainly, spending over one billion dollars annually on a system that far too often neglects, mistreats, and at times literally kills those it is intended to serve is a massive waste of money and, more importantly, life. *See Palmigiano*, 448 F.Supp. at 674 ("[A]lready the heavy financial costs, which the prison administration imposes by maintaining many prisoners [in unconstitutional conditions], fall on the taxpayers; this cost should soon be diminished. The citizens of this state also bear the human costs of operating a degraded prison system.").

Even focusing just on money, the expert testimony indicates that there are substantial inefficiencies in the system, and the Court's own observations at San Quentin and the California Institute for Men mirrors that evidence. As just one example, from the testimony and the Court's discussion with staff at San Quentin it is clear that large amounts of phamaceuticals end up being thrown away for no reason other than mismanagement. The Court has little doubt that the degree of waste experienced by the CDCR in the past can be reduced substantially by a Receiver.

(7) Likelihood of a Quick and Efficient Remedy

No doubt the reform of the CDCR medical system will be a monumental task. The preparation and execution of an effective plan to bring the prison medical system up to constitutional standards will require intimate knowledge and understanding of the way the [47] CIDCR operates from both the medical and custodial perspectives, a keen grasp of the reasons for the present crisis, an appreciation of the positions of each interested stakeholder, an understanding of financial and budgetary factors, and an ability to navigate the state bureaucracy and to make it responsive to the plaintiffs' needs. Making an appreciable impact may take many months, and a full remedy will take years. While this may not be "quick" in some contexts, the speed of reform must be judged relative to the scale of the project, which in his case is enormous.[8] The Court believes that steady progress here under the direction of a Receiver is possible, that gains in patient care will be made along the way, and that this is far preferable to the current state of paralysis.

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[8] The Court has referred to this case, and the task at hand, as humongous, and indeed it is. Nevertheless, judicial control of state-wide prison systems is nothing new. In fact, the Court is aware of ten other states in which court orders involving the totality of conditions in the entire prison systems were issued. *See* JUDICIAL POLICY MAKING at 41, 81.

(8) Additional Considerations

a. The Problem of Democratic Debilitation

Looking at the full spectrum of powers typically exercised by the courts, there is no doubt that the imposition of a Receivership is a drastic measure. But it is not a measure that the Court has sought, nor is it one the Court relishes. Rather, the Court is simply at the end of the road with nowhere else to turn. Indeed, it would be fair to say that the Receivership is being imposed on the Court, rather than on the State, for it is the State's abdication of responsibility that has led to the current crisis. *See Judge Rotenberg Educational Center*, 677 N.E.2d at 150 ("[W]hen the executive persists in indifference to, or neglect or disobedience of court orders, necessitating a receivership, it is the executive that could more properly be charged with contemning the separation principle."). Since the Court has jurisdiction over this matter, it has no choice but to step in and fill the void. But this is a disturbing result, not simply because it is a drastic measure for the Court, but because it exhibits a debilitation of the democratic process whereby the State executive branch has effectively turned over its obligations to the federal judicial branch. *See Shaw*, 771 F.Supp. [48] at 763 ("In essence, it is the Court's view that the Defendants are, at least in part, 'passing the buck' to it. Well, if it may appropriately be said, the 'buck stops here' for the Court is constitutionally bound to 'pick up the gauntlet.'"). This dual problem implicating concerns of separation of powers and comity unfortunately will remain until the State proves itself ready to regain control of the prison medical system.

b. The Lack of Political Will

The Court also recognizes the inherently political nature of this matter. To a significant extent, this case presents a textbook example of how majoritarian political institutions sometimes fail to muster the will to protect a disenfranchised, stigmatized, and unpopular subgroup of the population. This failure of political will, combined with a massive escalation in the rate of incarceration over the past few decades, has led to a serious and chronic abnegation of State responsibility for the basic medical needs of prisoners. This is a case where "the failure of the political bodies is so egregious and the demands for protection of constitutional rights [is] so importunate that there is no practical alternative to federal court intervention," *Discretionary Constitution* at 697; *see also Shaw v. Allen*, 771 F.Supp. 760, 763 (S.D.W.Va. 1990) ("[T]he Court is . . . not so naive as to fail to recognize . . . that factors of a 'political' nature are also guiding the Defendants. Certainly, it may be said without a great deal of reservation that the expenditure of a significant portion of a limited budget so as to protect the constitutional rights of prisoners is not a paramount concern in the minds of many citizens. In fact, many may inappropriately consider it both an unnecessary and unwarranted expenditure of public funds."); *see also* JOHN IRWIN, THE WAREHOUSE PRISON: DISPOSAL OF THE NEW DANGEROUS CLASS 150 (Roxbury Publishing Company 2005) (explaining that state governments are unwilling to allocate resources to prisoners because their "needs rank at the bottom of the state's priorities."). The legal response to this political issue, however, is quite clear: When the state deprives individuals of their liberty, for whatever reason, it takes upon itself the obligation to provide those persons with certain services basic to their humanity, including medical care. *See Estelle*, 429 U.S. at 103 (citations omitted) (adopting "common-law view that '[i]t is but just that the public be [49] required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'").

c. The Importance of Qualified and Dedicated Medical Staff

The Court does not wish to give the impression that all doctors working within the CDCR are incompetent or uncaring. For those who have violated their Hippocratic oath, they must take personal responsibility for their failures, even in light of the leadership failures discussed above. But the Court is personally aware of a number of doctors, nurses, and other medical staff members who have been struggling to provide quality care in dire circumstances. For these individuals the Court has nothing but praise. The Court wishes to encourage all of these medical professionals to continue their good work in the knowledge that California is about to embark on a dramatic transformation of its prison medical system. This message is intended as well for those medical professionals who have left CDCR employment in frustration, or who may consider applying for work in CDCR in the future.

On a related point, the Court is encouraged by the role that the unions representing medical staff have played in this process by submitting an amicus brief in support of the Receivership. The Court looks forward to working with the unions toward the commonly shared goal of saving lives and improving health care in the CDCR.

C. Conclusion

In light of all of the above, the Court concludes that the relevant factors and considerations weigh heavily in favor of the imposition of a Receivership in this case. While this is a step that no court takes lightly, this Court concludes that the record in this case compels this result and offers no realistic alternative. The Court further finds that the establishment of a Receivership, along with those actions necessary to effectuate its establishment, are narrowly drawn to remedy the constitutional violations at issue, extend no further than necessary to correct a current and ongoing violation of a federal right, and are the least intrusive means necessary to correct these violations. The Court is amply satisfied that this relief will impose no unnecessary burden on defendants and will have no adverse [50] impact on either the safety of the public or the operation of the criminal justice system.

It bears emphasizing that establishment of the Receivership, while absolutely necessary, is intended as a temporary, not permanent, measure. The Court looks forward to the day, hopefully sooner rather than later, when responsible officials of the State will assume their legal obligations to run the CDCR in a manner that provides constitutionally adequate health care to all prisoners. As the Supreme Court has instructed, "[a] receivership is only a means to reach some legitimate end sought through the exercise of the power of a court of equity. It is not an end in itself." *Gordon*, 295 U.S. at 37. Once the Court is confident that defendants have the capacity and will to provide such care, the Court will relinquish control from the Receiver back to the State.

Lastly, the Court wishes to make clear that it intends to remain actively involved in the Receivership phase of this case, working in tandem with the Receiver to ensure the design and implementation of a constitutionally adequate remedy, and the return of control to the defendants, in the shortest time possible. While the Receiver will be imbued with the poWer and authority to act in the name of the Court as the Court's officer, ultimate authority, as well as responsibility, lies with the Court alone.

II. The Court Will Hold the Remedy of Contempt in Abeyance

A contempt finding is not a prerequisite to the appointment of a receiver. *See, e.g., LaShawn A.*, 887 F.Supp. at 300 ("The Court, not eager to engender resentment among the defendants and their employees, declined to grant the plaintiff's motion for a finding of contempt and held it in abeyance, even though 'contempt may well [have been] justified.'"); *Gary W*, 1990 WL 17537 at *30; *Newman*, 466 F.Supp. at 635; *Morgan*, 540 F.2d at 533. In the discussion above, the Court has made explicit its expectations of defendants in terms of facilitating the Receivership and eradicating bureaucratic barriers to future success. While the Court has confidence that these expectations will be met, the contempt remedy remains an available tool to address any failures in this regard.

[51] FURTHER PROCEEDINGS

During the course of the evidentiary hearing pertaining to the Order to Show Cause, plaintiffs filed an ex parte motion with the Court requesting the immediate appointment of a temporary receiver. Plaintiffs proposed that the Court's medical experts be appointed as temporary receivers and that they be given the limited role of improving physician staffing. There is support for the proposition that courts may appoint temporary receivers in appropriate circumstances. *See e.g., Morgan*, 540 F.2d at 533 (approving temporary receivership of South Boston High School to ensure immediate transfer of certain staff who were impeding desegregation goal); cf. *LaShawn A.*, 887 F.Supp. at 300 (court imposed two "limited receiverships" in child welfare system at time consent agreement was entered; after subsequent noncompliance, court imposed a full receivership); TREATISE ON RECEIVERS at 21.

Plaintiffs' motion was based on their understandable concern that class members were suffering continued harm as the legal proceedings progressed. The Court has openly shared this concern, as expressed in the oral ruling on June 30, 2005. In fact, the Court initially was strongly inclined to appoint a temporary receiver pending a more thorough, systematic search for a Receiver. Thus, in July 2005, the Court began the process for the selection of a temporary receiver by consulting with the parties and sending a request for proposals to potential candidates recommended by counsel.

It became clear to the Court, however, during the process of reviewing proposals for a temporary receivership and interviewing candidates, that appointment of a temporary receiver would not be appropriate in this instance. The Receiver necessarily will have to engage in wholesale systemic reform given the polycentric and pervasive nature of the problems afflicting the CDCR. Such wholesale reform cannot effectively be initiated by a receiver with only very temporary authority. Furthermore, piecemeal reform that focuses on a limited aspect of the problem may actually prove counterproductive in the long run. Rather, the only effective approach to reforming the state prison medical system, and reducing harm to plaintiffs in a sustainable fashion, must be comprehensive and systemic [52] from the outset. As such, the Plaintiffs' request for appointment of a temporary receiver shall be denied.[9]

Accordingly, the Court is presently engaged in the process of appointing a full Receiver with the leadership, commitment, experience, and vision to take on the monumental and critical task of bringing the level of medical care provided to California's 165,000 inmates up to constitutional standards. In undertaking this task, the Court is committed to discharging its obligation to ensure that it has appointed the best possible person to undertake this unusually complex and critically important challenge. To this end, the Court has concluded, based on its experience to date in this process, that it is essential to undertake a professionally organized national search for a Receiver. While the Court has initiated this process, and intends to proceed as expeditiously as possible, while also consulting counsel, it recognizes that this undertaking necessarily will take some time to conduct in a responsible manner. The Court concludes that any limited delay will be far outweighed by the benefit of ensuring the superiority of the Court's ultimate appointment.

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[9] Although Plaintiffs never formally withdrew their request for appointment of a temporary receiver they have informally indicated to the Court that, in light of information learned during the process of interviewing candidates for a temporary receiver, they concur in the conclusion that appointment of a temporary receiver is not a practical approach in this instance.

During the current interim period prior to the appointment of the Receiver, the Court wishes, of course, to minimize the ongoing injury to the plaintiff class, given the life threatening impact of the ongoing constitutional violations. To this end, and by a separate order filed contemporaneously herewith, the Court is appointing a Corrections Expert, experienced in prison medical care reform and with extensive knowledge of CDCR operations, to make recommendations to the Court as to discrete remedial measures that can be undertaken immediately without interfering with the comprehensive and systemic reform that the Receiver necessarily will undertake. The Court emphasizes that the Corrections Expert will not be a temporary receiver and will not have the powers, authority, or responsibilities of a temporary receiver. Rather, the Corrections Expert will be limited to [53] preparing recommendations to the Court regarding potential remedial orders that will not interfere with any systemic reform efforts that the Receiver may undertake. Once the Court selects a Receiver, the Court will issue a separate order of appointment outlining the responsibilities and powers of the Receiver.

IT IS SO ORDERED.

DATED October 3. 2005

/s/ Thelton E. Henderson
THELTON E HENDERSON
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

NO. C01-1351-T.E.H.

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants,

RECEIVER'S FIRST BI-MONTHLY REPORT

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[1] I.

INTRODUCTION.

The Order Appointing Receiver ("Order") filed February 14, 2006 requires that the Receiver file his "Plan of Action" within 180-210 days. In the interim, the Order calls for the Receiver to undertake "immediate and/or short term measures designed to improve medical care and begin the development of a constitutionally adequate medical health care delivery system." Order at page 2-3. In addition, pursuant to page 3, lines 16-22 of the Order, the Receiver must file with the Court on a bi-monthly basis status reports concerning the following issues:

> A. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.

B. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.

C. Particular success achieved by the Receiver.

D. An accounting of expenditures for the reporting period.

E. Other matters deemed appropriate for judicial review.

The Receiver reports on issues B though E below.[1] Before this reporting, however, the Receiver believes it important to place the initial activities of his Office into context. He begins with the Findings of Fact and Conclusions of Law re Appointment of Receiver ("Findings of Fact and Conclusions of Law") filed October 3, 2005.

The Court iterated its rationale for placing the California Department of Corrections and Rehabilitation ("CDCR") medical care system into Receivership in the Findings of Fact and Conclusions of Law. The Receiver has been mindful of the Findings when conducting his duties and responsibilities to date. The Receiver has not only verified the Findings but, unfortunately, he has as well concluded that the situation in California's prisons is, perhaps, worse than the [2] descriptions provided in the Findings of Fact and Conclusions of Law. Because of this, the remedies envisioned may be more dramatic, far reaching and difficult to achieve than previously envisioned. Therefore, in addition to discussing the issues required by the Order, the Receiver will address below three additional issues of importance:

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[1] Given that the 180 day Plan of Action is not yet prepared, there will be no status report concerning the plan in this report.

(a) the state of the State of California; (b) the waste of taxpayer resources, and (c) efforts to establish the Office of the Receiver.

II.

THE STATE OF THE STATE OF CALIFORNIA

The Receiver has conducted dozens of meetings concerning the medical care provided inside California's prisons during his first sixty days of appointment. He has met and conferred with counsel for the parties, spoken formally and informally with literally dozens of State of California employees, from Governor Arnold Schwarzenegger to the heads of California's control agencies, executives from the CDCR, and correctional staff and health care clinicians working inside the walls of five prisons (San Quentin, the California Institute for Men, the California Institute for Women, the Central California Womens Facility and the Valley State Prison for Women). He has also interviewed inmate/patients. In addition, the Receiver has met with officials of the bargaining units who represent medical care providers in the CDCR, including the Union of American Physicians and Dentists ("UAPD"), the Service Employees International Union ("SEIU"), the California Correctional Peace Officers Association ("CCPOA") and the American Federation of State, County, Municipal Employees ("AFSCME").

The Receiver also reviewed thousands of pages of documents, including budget proposals, inmate/patient medical care charts, internal affairs investigations, policies and procedures, incident reports, memoranda from counsel, and the reports of the Court experts. In addition, as explained below, the Receiver has aggressively moved to assemble a team of top quality staff, including experts in both corrections and medical care. Based on all of the information reviewed and considered during the initial 60-days of the Receivership, the Receiver finds as follows:

[3] A. The medical services provided by the CDCR are without question "broken beyond repair," as found by the Court in the Findings of Fact and Conclusions of Law. Almost every necessary element of a working medical care system either does not exist, or functions in a state of abject disrepair, including but not limited to the following: medical records, pharmacy, information technology, peer review, training, chronic disease care, and speciality services. Similar to the conditions reported by the Court, the Receiver has observed cases where inmate/patients did not receive adequate care because of their inability to access care; also, and perhaps more disturbing, he has reviewed cases where inmate/patients did not receive adequate care even after accessing the CDCR medical care system.

B. The Receiver commenced the task of raising the level of medical care provided to California prison inmates up to constitutional standards with the assumption that prison medical care services will remain, at least in the near term, within the overall framework of the California correctional system. However, two very serious impediments may, over time, render the Receiver's assignment difficult, if not impossible, to complete:

1. Systemic Long Term Overcrowding: Most California prisons operate at 200% of capacity, with no effective relief in sight. Unless and until the living conditions of some prisons and the overpopulation experienced system-wide is effectively addressed, the Receiver will be impeded in applying systemic and even some ad hoc remedies to the medical care system.

> 2. Instability of Leadership: The Receiver has already dealt with no fewer than three Secretaries or Acting Secretaries of the CDCR. As well, the reassignment, retirement, promotion, or demotion of numerous wardens has significantly contributed to the instability, demoralization and ineffectiveness of the CDCR in both its custody as well as medical care responsibilities.

Given this state of affairs, and the poor reputation that the CDCR has earned as an employer, raising the medical system to constitutional standards may require removing it from the umbrella of the CDCR.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

NO. C01-1351-T.E.H.

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants,

RECEIVER'S SECOND BI-MONTHLY REPORT

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* * *

[2] II.

THE STATE OF THE STATE OF CALIFORNIA (CONTINUED)

As indicated in the First Bi-Monthly Report, dysfunction, paralysis, trained incapacity, broken business practices and political machinations of State government are root causes of the devolution of the prison medical care system to its present unconstitutional level. It is, perhaps, axiomatic that unless and until these root causes and "environmental" conditions within which the CDCR medical care system operates are significantly mitigated and ultimately changed, constitutional levels of access to and quality of medical care will not be achieved. As will be detailed below, given the scope and interconnection of the problematic conditions which were created by decades of inaction and mis-management, the challenges ahead are immense, the barriers from the body politic and bureaucracy continue and progress, while already begun, will be measured and must be very carefully managed.

The State's entrenched unwillingness and/or incapability to effectively discuss, let alone act upon, the crisis in California's prisons underscores the critical importance of the Court and the Receivership in its attempts to assure inmate/patients of their constitutional rights. Perhaps no more salient example of State paralysis has been the recently concluded Special Session of the Legislature. On June 26, 2006 the Governor declared the California prison system in crisis and called a special session of the Legislature to deal with the issue of severe overcrowding, the root cause of many of the prison system's ills, including constitutionally inadequate medical care. Instead of the different entities of the State working together, some observers voiced immediate criticism of the Governor's action, calling it "too little, too late." Other critics were cynical regarding the potential for meaningful action when the Governor declared sentencing reform and reform of existing parole violation policies "off the table." Because 2006 is an election year, still others characterized the call for a special session as a "political stunt" armed at applying pressure to the Legislature to take action, affirmative or negative, on various proposals put forward by the Governor in an attempt to, if nothing else, share blame should nothing meaningful eventuate from the session.

[3] Despite dire warnings from CDCR administrators that California's prisons will be out of space by June 2007, despite the fact that population levels are now in excess of 200% of designed capacity, nothing was

presented to the Legislature by the Administration that provided for immediate relief for Prison Wardens and Health Care Mangers. Likewise, the Legislature itself offered no realistic proposals to deal with the problems faced within California's prisons in a timely and adequate manner.

The Receiver, however, offered comments and suggestions on the special session in a letter to the Governor and legislative leaders dated July 24, 2006, attached as Exhibit 1.[2] Although not intended for the necessary immediate relief concerning overcrowding, the Receiver's proposal would have both mitigated overcrowding and begun a construction process that is without question one element of a comprehensive plan to raise the health care services in California's prisons to constitutional levels. To the credit of the Governor and Senate, the Receiver's suggestions, as modified during the session, were adopted. For reasons not disclosed, however, the Assembly did not approve the Governor's revised plan to build medical/mental health assets. In the end, nothing productive eventuated from the special session and yet again cynicism proved prophetic and the gubernatorial declaration of a crisis in California's prisons was, effectively, left unaddressed.

This inaction, planned or otherwise, is emblematic of other examples of political paralysis in the State of California. Another recent example of similar State behavior was evidenced in the Receiver's call for salary increases (spoken to later in this report) for clinical personnel. Rather than taking a proactive stance toward such increases, which were well documented by the State itself in its own salary surveys, the State chose to leave it to the Receiver and Court to order such increases, at an attendant additional cost to taxpayers and delay in implementation.

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[2] Exhibits are provided in an Appendix of Exhibits filed concurrently with this Report.

The State's unwillingness and/or inability to take remedial action, and the depth of the problems in the prison medical care system (as detailed in this report) brings to mind

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C01-1351-T.E.H.

MARCIANO PLATA , *et al.*,
Plaintiffs
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants,

RECEIVER'S REPORT RE OVERCROWDING

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[1] I.

INTRODUCTION

In the Order filed February 15, 2007 the Court directed "the Receiver to report to the Court within 90 days of the date of this Order, his best assessment of the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue." *Order* at 4:3 - 13. The Order also called for the Receiver to provide the Court with information concerning the "types of obstacles" that overcrowding presented to the Receivership. *Id.*

This report responds to the Order. It is organized as follows:

Section II. summarizes the findings which led to the Receivership. It also references the Receiver's Plan of Action concerning those remedial programs necessary to bring California's prisons up to constitutional standards.

Section III explains the special characteristics of prison overcrowding in California. As explained below, the specifics of prison crowding are far worse than previously explained by State officials. Furthermore, the characteristics of overcrowding within California's massive prison system have especially adverse consequences concerning the delivery of medical, mental health, and dental care. The impact of overcrowding presents complicated problems, challenges which further complicate the already difficult remedial challenge faced by the Receivership. Thus, very specific information relative to the real-life impact of overcrowding is necessary to provide relevant background data concerning the types and the scope of crowding related obstacles that interfere with the remedial programs developed by the Receiver.

Section IV summarizes the manner by which overcrowding interferes with the Receiver's remedial projects, discussing both "substantive" and "process" related interference. Section V analyzes the real life impact of the recent 2007 California Legislation.

Section VI provides a conclusion concerning the Court's directives of February 15, 2007.

[2] II.

CONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

The California Department of Corrections and Rehabilitation ("CDCR") has failed to deliver constitutionally adequate medical care to the more than 170,000 prisoner/patients presently incarcerated in the State of California. There are three relevant frameworks of analysis within which it is possible to summarize the "constitutional violations at issue" referenced in the Court's February 15, 2007 Order.

B. Court's Findings of Fact and Conclusions of Law of October 3, 2005.

The Court's Findings of Fact and Conclusions of Law re Appointment of Receiver filed October 3, 2005 set forth facts which demonstrated that California, prison medical delivery system was broken beyond repair, holding that future injury and death was virtually guaranteed in the absence of drastic action. Those findings will not be repeated here; however, the Receiver believes it important to point out the following. As found by the Court, California's prison medical care crisis has persisted for decades. And while the State had ample opportunity to improve medical conditions, it failed to do so. The failure was caused, to a significant degree, by institutional paralysis and a lack of will. The State's response to decades of overcrowding is similar; despite various task forces, numerous studies and reports, and Special Sessions, California has not instituted any effective response to the worsening overcrowding crisis.

C. The Receiver's Bi-Monthly Reports.

The Receiver has submitted four Bi-Monthly Reports. Each provides up-to-date information concerning the deplorable state of California's prison medical care delivery. To summarize, the Receiver concludes that the degree of operational chaos within the CDCR, the institutional paralysis in many State agencies, and trained incompetence are even worse than indicated by the Court's findings.

[3] D. Defendants' Inability to Provide Basic Medical Care Services Required by Plata Stipulations.

1. *Introduction.*

The final relevant measure of the "unconstitutional violation at issue" is the twenty-eight basic prisoner/patients services called for by the June 13, 2002 Stipulation for Injunctive Relief. These are the services which the State, for more than five years, had failed to provide.

2. *Provisions for Prisoner/Patient Services.*

1. Health screening: A process for screening all patients for communicable disease, such as tuberculosis and sexually transmitted disease, and chronic disease, such as diabetes, renal disease, seizure disorders, cardiovascular disease, and pulmonary

disease; screening for cancer; review of vital signs, blood pressure, pulse, and weight; review of current medications; and nurse review and referral for patients with urgent or acute conditions; history and physical examination for all patients within 14 days of arrival at Reception Center; and routine laboratory tests, such as serum pregnancy, cholesterol screening, and optional HIV testing. (Stipulated Injunction ¶ 4)

2. Health transfer: Process to ensure continuity of care when patients transfer to another institution, transfer between levels of care, or are paroled, including continuity of medications, specialty referrals, and other treatment. (Stipulated Injunction ¶¶ 4, 6)

3. Access to Primary Care (Sick Call): System that allows patients to self-refer for medical treatment, including nurse review to identify the need for immediate referral to urgent or emergency treatment, an urgent walk-in procedure, and follow-up services; policies require face-to-face nurse triage for patients with symptoms within 24 hours, and an appointment with a primary care provider within 5 days for patients classified as urgent and within 14 days for patients classified as routine. (Stipulated Injunction ¶ 4)

4. Priority Ducat System: System for ensuring that custody staff treat health care appointments as high-priority. (Stipulated Injunction ¶¶ 4, 6)

5. Patient Health Care Education: Program to provide patients with instruction in wellness, lifestyle changes, disease prevention, newly diagnosed illness or disease, treatment [4] plans or procedures, pre-

and post-operative care, chronic care morbidity reduction. (Stipulated Injunction ¶ 4)

6. Preventive Services: Services to prevent disease and mitigate morbidity and mortality due to existing disease provided to select patient populations based upon risk factors, such as age and chronic conditions, that include cancer screening, immunizations, and health education (education regarding diet, exercise, smoking cessation, etc.). (Stipulated Injunction ¶ 4)

7. Outpatient Specialty Services: Program for providing specialty services, including procedures for urgent and routine referrals and required follow-up; policies require that high-priority consultations or procedures occur within 14 calendar days and routine consultations or referrals within 90 calendar days, with follow-up by a primary care provider within 14 calendars days after the consultation or procedure. (Stipulated Injunction ¶ 4)

8. Physical Therapy: Program to ensure timely access to physical therapy services, including specifications for the follow-up by primary care providers and provisions for transferring to an institution with these services if the home institution does not provide them. (Stipulated Injunction ¶ 4)

9. Diagnostic Services: Program for the appropriate processing of laboratory tests and other diagnostic testing, including procedures for prioritizing the urgency of laboratory orders (STAT, critical, urgent, routine) and required timeframes for review and follow-up of results (routine laboratory tests processed within 14 days of order, x-ray examinations completed within 30 days of order, primary care provider review of lab results within two business days of

receipt, notification of patient of results within 14 days of receipt). (Stipulated Injunction ¶ 4)

10. Medication Management: Services to dispense, administer, and distribute pharmacotherapeutic treatments, including provisions for medication error reporting, medication follow-up counseling, medication renewals and refills, medication for parole, and continuity of medication upon transfer; policies require that prescriptions for formulary medications be filled by the following day and that "stat" medications be issued within 1 hour. (Stipulated Injunction ¶ 4)

[5] 11. Urgent/Emergent Response: Program for the provision of urgent care services and 24-hour emergency medical treatment that includes basic life support, emergency response, and physician on-call services; policies require follow-up within five days for patients whose urgent encounter was due to chronic disease. (Stipulated Injunction ¶¶ 4, 6)

12. Medical Emergency Response Documentation and Review: Process for the review of deaths, suicide attempts, and calls for emergency assistance to determine compliance with existing policies and procedures, adequacy of response time, and appropriateness of custody and medical response and patient treatment, with follow-up actions to address identified deficiencies. (Stipulated Injunction ¶ 4)

13. Outpatient Housing Unit and Licensed Care: Specialized treatment services for varying levels of acuity, including outpatient services requiring specialized housing (Outpatient Housing Unit care), licensed skilled nursing facility care (Correctional Treatment Center care), General Acute Care Hospital care, and palliative care; policies require physician

evaluation within 24 hours of admission to a Correctional Treatment Center and an evaluation by a primary care provider within 5 days for all patients returning from an inpatient acute care facility. (Stipulated Injunction ¶ 4)

14. Outpatient Therapeutic Diets: Program for the provision of nourishments and supplements for patients who are pregnant, diabetic, immunocompromised, malnourished, or have oropharyngeal conditions causing difficulty eating regular diets and special diets for patients with renal failure or hepatic failure, or who require a Heart Healthy diet, gluten-free diet, or diet to preclude food allergies. (Stipulated Injunction ¶¶ 4, 6)

15. Medical Report of Injury or Unusual Occurrence: Process for documentation of patients' on-the-job injuries, physical contact with a staff member during an incident, and any self-reported injury due to self-injury or altercation, Administrative Segregation Unit placement, use of force, or other medical emergency situation. (Stipulated Injunction ¶¶ 4)

16. OC Contraindications: Process for the evaluation and treatment of patients prior to or after the use OC. (Stipulated Injunction ¶¶ 4)

[6] 17. Medical Evaluation of Patients Involved in Assaults: Process for the evaluation of patients who have been involved in the use of force, including review of the patient's mental health record. (Stipulated Injunction ¶¶4, 6)

18. Hygiene Intervention: Process for the identification, evaluation, and referral of patients who demonstrate poor hygiene or whose hygiene compromises the sanitation/hygiene of their personal and immediate housing area. (Stipulated Injunction ¶ 4)

19. Inmate Hunger Strike: Process for the identification, evaluation, and treatment of inmates on hunger strike, including required coordination and reporting between custody and health care staff. (Stipulated Injunction ¶ 4)

20. Comprehensive Accommodation Chrono: Process for the authorization and review of special equipment, housing accommodations, or other accommodations that are medically necessary or are required under the Americans with Disabilities Act. (Stipulated Injunction ¶ 4)

21. Pregnant Patient Care and the Birth of Children: Prenatal care and post-delivery services, including required screenings, frequency of prenatal treatment visits, vitamin and nutritional requirements, referrals for child placement services, and post-partum follow-up; policies require that patients be seen by a obstetrics provider within 7 calendar days of determination of pregnancy that each patient be provided six-weeks post-delivery for follow-up. (Stipulated Injunction ¶ 4)

22. Nursing Services and Protocols: Clinical protocols for nurses in the appropriate evaluation and treatment of patients presenting with specific systemic conditions or complaints. (Stipulated Injunction ¶¶ 4, 6)

23. Health Record Services: Provisions for the management, content, and archiving of patient health records, including policies for disclosure of information. (Stipulated Injunction ¶ 4)

24. Chronic Care Program: Diagnosis and management of chronic disease (diseases lasting longer than 6 months), including identification and treatment of high-risk patients; policies require an

initial intake evaluation within 30 days for patients referred to the Chronic [7] Care Program, and ongoing evaluations every 90 days. (Stipulated Injunction ¶¶ 4, 6)

25. Pharmacy Services: Provisions governing pharmacy operations, including pharmacy licensing, emergency drug supplies, drug storage, consultation with a pharmacist, prescription requirements, and the ordering, stocking, and receiving of medications. (Stipulated Injunction ¶ 4)

26. Public Health and Infection Control: Program for infection control, communicable disease reporting, and bloodborne pathogen control. (Stipulated Injunction ¶ 4)

27. Telemedicine Services: Program for the provision of specialty services through videoconferencing. (Stipulated Injunction ¶4)

28. Utilization Management: System to facilitate appropriate use of resources for patients requiring higher levels of care and select specialty services and medications, including reviews to determine placement at appropriate level of care and appropriate utilization of specialty care and pharmacy resources. (Stipulated Injunction ¶ 4)

3. *The Receiver's Plan of Action.*

On May 10, 2007 the Receiver filed his initial Plan of Action to remedy the unconstitutional medical care system in California's prisons. (Exhibit 1.)[1] As set forth in the Plan, the CDCR requires an entirely new infrastructure of medical delivery before necessary programs of clinical remediation can be effectively implemented in a sustainable manner. Therefore, when considering "the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue," the Receiver necessarily referred not only to the stipulated injunctions re medical delivery (standards agreed to by the attorneys in this case), but also to the substance of the Plan of Action that will be necessary to successfully remedy the unconstitutional medical conditions in California's prisons.

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[1] All exhibits referenced in this report are found in the Appendix of Exhibits Supporting the Receiver's Report Re Overcrowding filed concurrently with this Report.

[8] E. Unconstitutional Medical Conditions Are Only One Part of an Unconstitutional Prison Health Care Delivery System.

Context is critical. The State of California has allowed its massive prison system to operate with unconstitutional levels of medical care. At the same time, however, the State is under Federal Court mandated remedial plans concerning the delivery of Mental Health, Dental, and Americans With Disability Act services. Under the best of circumstances, correcting medical problems present a significant challenge; however when the medical remedial plan must also consider the legitimate remedial objectives of the *Coleman*, *Perez*, and *Armstrong* class actions, in addition to uncontrolled overcrowding, the scope, duration, and cost of Federal Court intervention may increase dramatically, as explained below.

III.

THE SCOPE AND CHARACTERISTICS OF PRISON OVERCROWDING IN CALIFORNIA

A. Introduction.

From the perspective of a Receivership tasked with creating a medical delivery system that meets constitutional minima, the size, scope, pervasiveness and specifics of overcrowding in California's prisons have special negative consequences, as explained below.

B. The Pervasiveness of Prison Overcrowding in California.

1. *Introduction.*

Prison overcrowding is not a new phenomenon in California. To the contrary, overcrowding has been a way of life in the CDCR for twenty years. For example, as demonstrated below, overcrowding is ingrained in the CDCR style of constructing and managing prisons. Crowding related policies that do not provide adequate clinical and program space are now an accepted practice of CDCR prison planning, as is California's practice of offering inadequate salaries and failing to provide adequate hiring programs which have created crisis levels of shortages of clinical personnel and correctional officers.

[9] 2. *The Long Term Continuation of California Prison Overcrowding.*

Despite spending billions of dollars on construction, the level of overcrowding in California's prison system has not decreased; indeed, despite waves of prison expansion overcrowding has now reached crisis levels.

Exhibit 2 charts prison by prison and system-wide overcrowding from June 30, 1997 to May 4, 2007.[2] To summarize, in 1997 there were a total of 32 prisons within the CDCR with an average overcrowding rate of 196.0 percent for Males and 175.3 percent for

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[2] The chart was created based on the data obtained from the CDCR's Data Analysis Unit (from the "Monthly Report" for the dates specified).

Females. In 2002 there were 33 institutions (with the additional of Substance Abuse Treatment Facility ("SATF")) and an average overcrowding rating of 191.3 percent for Males and 155.9 percent for Females. In 2007 the number of institutions remained at 33.[3] The Statewide overcrowding average for Male inmates increased to 196.4 percent and the Female overcrowding rating increased to 175.8 percent. In 1997 there were 11 institutions at or above 200 percent of overcrowding. By 2002 that number had increased to 12 institutions. By 2007, 19 institutions were at or above 200 percent of overcrowding. To summarize, despite massive waves of construction, prison overcrowding has grown worse in California.

3. *The Consequences of Decades of Overcrowding.*

No one disputes the consequences of decades of prison overcrowding; indeed, both formal studies and official proclamations affirm the crisis nature of today's overcrowding. For example:

a. Corrections Independent Review Panel.

Three years ago, June 30, 2004, an independent panel of experts, chaired by former Governor George Deukmejian issued a report entitled "Reforming Corrections." In a section titled "Inmate/Parole Population Management" the panel found California's prisons "filled to the [10] breaking point," exceeding both "safe and reasonable capacity" and "far exceeding operable capacity." (Exhibit 3.)[4] The panel also found that numbers alone understated the impact of overcrowding, that staffing reductions have accompanied overcrowding, and that overcrowding and inadequate staffing impedes programming. The panel made a number of crowding related recommendations, none of which have been implemented.

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[3] Kern Valley State Prison ("KVSP") was activated and Northern California Women's Facility ("NCWF") was deactivated.

[4] The entire "Reforming Corrections" report is found at cpr.ca.gov/report/indrpt/corr.

b. Little Hoover Commission Report.

On January 25, 2007 California's Little Hoover Commission issued a report entitled "Solving California's Corrections Crisis – Time is Running Out" finding that California's prisons are swelled past capacity, that as a result of crowding there was little room or budget for rehabilitation, that California had a recidivism rate of 70 percent (near the highest in the United States), and that thousands of correctional officer shortages have created huge overtime bills and mounting stress for those officers on duty. (Exhibit 4.)

c. Governor Schwarzenegger's Declaration of Emergency.

On October 4, 2006 Governor Arnold Schwarzenegger proclaimed a State of Emergency because of prison overcrowding, declaring that "the current severe overcrowding in 29 CDCR prisons has caused a substantial risk to the health and safety of . . . the inmates housed in them . . . The declaration further stated that overcrowding puts prisoner/patients in "increased, substantial risk for transmission of infectious illnesses."

4. A Progressive Lowering of Standards: CDCR Facilities Master Plans.

A telling example of the CDCR's institutionalized acceptance of overcrowding and the lowering of correctional standards to accommodate overcrowding is found in CDCR "Facility Master Plan" documents. Exhibits 5, 6, and 7 contain relevant sections from the CDCR's Facility Master Plan for 1993-1998, 1995-2000, and 1998-2003. Reviewed in sequence, they provide insight into a correctional mindset that allows *overcrowding* rather than *sound correctional management* to drive crucial construction and prisoner management policy. Note [11] the following:

1. No Master Plan addresses overcrowding driven problems with the delivery of medical services. All the plans focus on corrections, as if medical, mental health, and dental care have no place in prison design, *prison construction*, or *prison management*.

2. As the CDCR failed to "build its way out" of the overcrowding crisis, crowding restrictions were steadily lowered, until by the issuance of the 1998-2003 Plan there were essentially no restrictions. For example, the 1993-1998 Master Plan (Exhibit 5) limited celled crowding to 130 of design percent and dormitory crowding to 120 percent of design capacity. By the 1995-2000 Master Plan (Exhibit 6), however, a 170 percent crowding standard was utilized for *the highest security prisoners, Level IV*. The 1998-2003 Master Plan (Exhibit 7) allowed for a 190 percent crowding rate at almost all prisons (and for the housing of prisoners in gyms). During these same years various CDCR housing definitions were repeatedly modified, and new terms were instituted such as "crisis" and "nontraditional" (the CDCR's designation for prisoners housed in classrooms, hallways, etc.). Prison staff refer to such beds as "ugly" beds.

C. California Prison Overcrowding Is Accompanied by Severe Staffing Shortages.

1. *Clinical Staffing Shortages.*

The Receiver has previously reported to the Court about the serious clinical vacancy rates throughout the CDCR's medical delivery system. Likewise, reports have issued concerning staffing shortages in the *Coleman* and *Perez* class actions. When considering the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue, the Receiver must take into consideration the fact that overcrowding is accompanied by serious staffing shortfalls for both clinical providers and correctional officers.

For example, Exhibit 8 provides a snap shot comparison of clinical staffing shortages between January 31, 2002 and January 31, 2007.[5] Concerning every clinical category except for [12] registered nurses, vacancies are worse today than five years ago.[6]

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[5] One difficulty encountered by the Receiver when preparing this report is that limited and at times inaccurate staffing data is maintained by the CDCR. The figures in Exhibit 8 were obtained from the State Controller's Office; thus, there may be a time lag in the reporting of actual staffing shortfalls, as well as hires. Nevertheless, these numbers represent accurate "ball park" estimates of the scope of staffing shortages between 2002 and 2007. These numbers do not, however, consider future staffing enhancements and roll-outs. According to CDCR staff, hundreds of additional dental, medical, and mental health clinicians will be needed to comply with remedial plan standards.

The true scope of clinical staff shortfalls is actually *far worse* than the numbers set forth in Exhibit 8 because there are additional staffing needs projected in each of the health care class actions as well as upcoming time-phased "roll-outs," none of which are yet listed on the chart.

2. *Custody Staffing Shortages.*

Correctional officer vacancies on April 30, 2002 were 1,179. As of January 31, 2007 "budgeted" correctional officer vacancies had risen to 1,915.[7] However, the actual total of officer vacancies is several hundred higher than the "budgeted" vacancies due to the practice of assigning "unbudgeted" positions for posts such as medical guarding at community hospitals, and monitoring and providing services for prisoners confined to "nontraditional" beds. CDCR officials estimate the actual officer shortage to be somewhere between 2,400 and 2,700.

Based on response to numerous inquiries by the Office of the Receiver, there appear to be no innovative or unique CDCR program that has been developed to address the correctional officer shortage. To the contrary, the existing system of recruitment and hiring is experiencing bottlenecks in its recruitment process that may have an adverse impact on the number of cadets admitted to future academy classes.

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[6] Improved rates of hiring and retaining registered nurses are the result of the Receiver's salary increase and the Receivership's streamlined clinical hiring process.

[7] These figures were provided by the CDCR's Human Resources Division based on State Controllers Office data.

For example, according to CDCR personnel, as of Friday, May 11, 2007 there were somewhere between four to seven thousand "unassigned" background verifications awaiting processing (background checks are required for correctional officer applicants who successfully complete the CDCR's initial testing programs). The exact backlog is not known in that the background unit is behind in entering data into its computer tracking [13] system.

3. Managerial and Executive Staffing Shortages.

In addition to the severe staffing shortfalls within the ranks of clinicians and correctional officers, the CDCR has also experienced very significant turnover among its executive and managerial ranks, ranging from Secretaries to Wardens. Likewise, given the unconstitutional conditions in health services, turnover among prison Chief Medical Officers and Chief Physicians and Surgeons remains excessive.

D. The Short Average Length of Sentences Among California Prisoners.

According to CDCR statistical records, the average sentence for a California prisoner is 46.7 months, and the average time served is 24.1 months. (Exhibit 9.) Given the fact that California confines thousands of prisoners facing Life or Life Without the Possibility of Parole sentences, the CDCR average time served is indicative of two distinct classes of California prisoners: (1) longer term prisoners, a significant portion of whom (but not all) are confined to Level III and Level IV prisons; and (2) a group of short term prisoners (of whom a significant percentage are parole violators) who come into and go out of the CDCR with such frequency that the average length of CDCR sentences is pushed down to two years.

Each class of prisoner has different and distinct medical needs. Therefore, when implementing the Plan of Action, the Receiver must consider this characteristic of California prison crowding. Lifers, for example, will eventually age and require special housing as infirm patients. On the other hand, the constant churning of parolees into and out of the CDCR (and between CDCR institutions) requires special clinical and correctional support staff at reception centers and in the "receiving and release" units at each state prison.

E. The Impact and Severity of California Prison Overcrowding Varies By Institution.

1. *Introduction.*

The California prison system is unique not only in terms of its overall size and prisoner population, but also because of a wide variety of different types of prisons, the remote location of most prisons, and the different impacts of overcrowding at each specific institution. As a [14] result, overcrowding related negative impacts on the Plan of Action become both complicated and interrelated. There is no single fixed strategy that can be employed by the Receiver to bring medical care delivery in California's prisons up to constitutional standards. Invariably, the overcrowding problems at each specific prison are unique, and specialized remedial programs must be developed for each.

2. *Factors Which Determine the Impact of Overcrowding In California's Prisons.*

1. Degree of Overcrowding: As shown in Exhibit 2, not all CDCR prisons suffer from the same degree of

overcrowding. The challenge of providing constitutional medical care at a prison with more than two hundred percent overcrowded will be different from the challenge at a prison that is less crowded.

2. Institution Size: California opted to construct mega-prisons in the 1980s and 1990s, a strategy rejected by other jurisdictions. In addition, California has a policy of adding new prisons to sites with older prisons, creating a number of prison complexes (e.g. the California Institute for Men ["CIM"] and the California Correctional Institution at Techachapi ["CCI"]). Ultra-large prisons and prison complexes which are severely overcrowded, as they are today, create special medical delivery challenges, as well as recruitment difficulties.

3. Remote Location: Many of mega-prisons constructed in the 1980s and 1990s have been sited in remote locations, far from the urban centers where it may be possible to recruit adequate numbers of competent clinicians. With the remote prisons so severely overcrowded, recruitment problems have intensified, not only for clinical personnel but also for correctional officers.

4. Institutional Design: Because of overcrowding, many California prisons which should have been decommissioned decades earlier remain not only fully operational, but operate at 200 percent of their design capacity. Thus in terms of real life remedial fixes, it is a far different problem addressing the impacts of overcrowding on the aged, poorly maintained and diverse housing units at San Quentin or Old Folsom, compared to the impacts of crowding presented by [15] a prisoner population of more than 260 percent of design capacity as at the more modern

but sprawling and remotely-located prison located at Avenal.

5. Institution Mission: Many CDCR prisons have been charged with special "missions." Because there has been no adequate long-term planning in CDCR, prison specific missions have been assigned in a manner that inhibits the establishment of a safe and effective medical remedial plan. In most cases the designation of CDCR prison "missions" are comprehendible only in a historical context. The diversity, lack of organization among missions, ad hoc and incompetent changes in mission combined with severe crowding will complicate the timely and cost effective implementation of the Plan of Action, especially when the Plan calls for assigning the appropriate patient to the appropriate medical delivery facility.

For example, Avenal State Prison has been designated for *Armstrong* class members and for housing older, low security prisoners – despite its remote location and the resulting difficulties hiring adequate numbers of clinicians. Salinas Valley State Prison contains a long term "Intermediate" mental health facility for high security inmates, despite being hundreds of miles from outpatient mental health units at Pelican Bay State Prison ("PBSP") and California State Prison-Sacramento (which feed patients into and accept patients from the Intermediate unit). Prisoners with medical conditions that may make them especially vulnerable to Valley Fever, for example, patients with serious kidney problems, are housed in prisons in the Central Valley, the primary locus of Valley Fever spores, because those facilities have been designated for the delivery of dialysis treatment. Correcting these types of anomalies will be difficult, requiring an entirely new program of cohorting patients, which will in turn require modifications to the manner by which CDCR classifies inmates and assigns them to specific prisons. This challenge is rendered far more difficult, however, because of the extent of the CDCR's overcrowding.

F. The Velocity of Prisoner Movement Within the CDCR.

1. *Introduction.*

Overcrowding creates increased prisoner movement as correctional officials struggle to [16] manage crowding by transferring prisoners from institution to institution in a constant search for "open" beds. This form of crowding driven movement adversely impacts on health care delivery in at least six important ways. First, adequate health care in the correctional environment requires some form of "intake" or "reception" screening whenever a prisoner arrives at an institution. The health care screening (medical, mental health, and dental) that takes place at a CDCR Reception Center is necessarily wider in scope and more complete than the intake screenings which take place as a result of inter-prison transfers; nevertheless, both processes call for specific clinical reviews, reports, and the coordination of necessary follow-up care. Thus, an increase in prisoner movement equals an increased workload concerning screening. Second, all "out" transfers from a CDCR prison require action by health care staff, including, in some cases, an evaluation of whether the prisoner is fit for transfer. Third, the appropriate medical records must accompany the transferring prisoner. However, given the existing transportation process, the speed by which transfers need to be effectuated, and the absence of any form of electronic record, this means that a paper record must be assembled, updated, transported to the intake and release area and physically placed inside the transportation vehicle with the transferring prisoner for delivery to the reception nurse at the receiving institution in time for the intake screening. Not surprisingly, many prisoners are transferred without their records. Fourth, some percentage of inmates who are transferred must be provided with medication during the transfer process, and plans must be initiated for the timely renewal of medications at the receiving institution, placing an additional work load on physicians, pharmacy personnel, nurses and correctional officers. Fifth, some percentage of transferring inmates must be afforded special transportation (and in some cases must be accompanied by clinical personnel) during the transfer, a staff intensive procedure for both clinical and correctional personnel. Finally, transfer often adversely impacts patient clinician relationships and clinical programs (whether medical, mental health, or dental oriented). Given the scope of overcrowding, however, and an unceasing need for more and more transfers, the present CDCR system functions in a manner whereby classification driven decisions are primary, with medical/mental health/dental issues assuming a secondary and in [17] every instance unacceptably low level of importance.

2. *The Scope of Prisoner "Moves."*

Given the State's decision to construct very large correctional facilities and given the decision to site many prisons in remote locations, it is not surprising that CDCR effectuates hundreds of thousands of prisoner moves each year. Movement into and out of the CDCR, as well as between CDCR prisons has now reached crisis proportions. For example, Exhibits 10 through 12 provide a prison-by-prison summary of inmate movement into and out of specific institutions, as well as a systemic total, for the months of January, February, and March 2007.[8] In total there were *more than 170,000 prisoner moves during the, first quarter of calendar year 2007 alone.* CDCR reception centers were especially hard hit. For example, the California Institution for Men ("CIM"), a male reception center, averaged more than 11,000 prisoner moves each month.

3. *Mission Change and "Yard-Flips."*

In addition to an increasing velocity of prisoner movement and its adverse impact on attempts to deliver constitutionally adequate medical care, correctional officials in the CDCR are forced, because of the pressures of overcrowding, to constantly re-evaluate the correctional mission of each CDCR institution and to periodically alter those missions in order to provide housing for classifications of inmates for whom bed shortages have become especially acute.

Yard flips (a procedure whereby housing units or yards within a prison are designated for a different classification of prisoner) and mission changes (a procedure whereby an entire prison is designated for a different classification of prisoner) exemplifies yet another characteristic of California prison overcrowding: *the real life impact of crowding is not only*

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[8] Official CDCR statistics are reported by counting a prison transfer "out" and the resulting prison transfer "in" (at a different institution) as only one move. However, because both the transfer out and the transfer in require some form of health care intervention, this report totals all moves.

in the overall numbers, but also in the population pressures created by a lack of beds for specific classifications of prisoners. For example, an increase in long term violent offenders classified as [18] Level IV prisoners requires an increase in celled housing. An increase in short term non-violent offenders calls for increased housing in dormitories/lower security housing.[9]

Yard flips and mission changes are necessitated by classification related housing shortage. In essence, one classification of prisoner is moved out of a specific yard or prison and transferred to other institutions while a different classification of prisoner is moved into those units. Exhibit 13 summarizes CDCR bed conversions from February 2003 through May 2007.

It is important to emphasize that with increasing overcrowding, yard flips and missions changes have become an unceasing process. *See*, for example, Exhibits 14 - 16, three CDCR Memorandums issued the same day – March 30, 2007. The first calls for 11 emergency revisions to previously issued "Institution Activation Schedules," the second converts Facility D of the California State Prison at Los Angeles County ("LAC") from a Level IV General Population housing unit into a Reception Center, and the third converts Centinela State Prison from a Level III prison to a Level IV prison.

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[9] As explained below, when analyzing the impact Assembly Bill 900, creating additional CDCR dormitories will not address the crisis shortage of Level IV cells.

4. *The Heightened Negative Impact of Overcrowding on CDCR Reception Centers.*

Because of overcrowding, the Plan of Action faces special challenges relative to CDCR reception centers. For example:

1. One of the factors driving California prison overcrowding is the State's failure to implement rehabilitation programs. Therefore, in California, high percentages of paroled prisoners either "violate" their conditions of parole or "re-offend" with a new crime.

2. Thus CDCR reception centers have, during the past twenty years, encountered ever increasing prisoner movement pressures as more and more prisoners flow into the CDCR for relatively short terms of incarceration. As demonstrated by Exhibits 10 - 12, this flow into the CDCR has a special impact on reception centers such as CIM, SQ, the Deuel Vocational Institute ("DVI").

[19] 3. Reception centers are institutions which must be staffed and have the appropriate clinical space to provide a level of medical care and clinical evaluations above that of the general population institutions. When a former prisoner violates parole or re-offends, he or she returns to the CDCR through a reception center where a medical/mental health/dental health care appraisal must be performed. Once that appraisal is completed the newly received prisoner is transferred to an open bed at a prison which has been designated for his or her classification. However, none of the CDCR's designated reception centers were designed or constructed with adequate clinical space. To make matters worse, as the original prisons designated for reception

became overwhelmed by the influx of parole violators, the CDCR was forced to "convert" general population prisons into reception centers. These "conversions," however, were not accompanied by adequate additions to clinical staff or clinical space. For example when San Quentin, the State's oldest prison, converted to a reception center it was allocated an entirely inadequate temporary relocatable structure, which until the Receiver began his San Quentin Pilot Project, had not been renovated or replaced.

The degradation of CDCR reception process continues to this day. As Exhibit 15 demonstrates, because of overloads at other reception centers, slowly but surely, yard by yard, LAC is mutating into a full blown reception center. Although chapels and libraries have been converted into some additional clinical space, LAC has neither the staffing nor the clinical space to accomplish the health care elements of reception.

G. The State's Failure to Plan, Design, and Build Appropriate Newest and Most Modern Prisons.

The Receiver has discovered that the Plan of Action, as it relates to overcrowding, cannot assume adequate prison medical clinics/treatment area infrastructure exists even in California's newest and most modern prisons. To the contrary, when measuring the impact of overcrowding on his remedial efforts, the Receiver is forced to consider the following two facts:

(1) the newest CDCR prisons were designed with clinic space which is *only one-half that necessary for the real-life capacity of the prisons*; and

[20] (2) while millions of dollars have been allocated for prison health care space projects during

the past five years, the great majority of the project were never completed; indeed, some projects do not appear to exist.

1. *Inadequate Clinical Support Space in the State's Newest and Most Modern Prisons.*

In the beginning of the prison construction boom in the early 1980s, the CDCR developed a "Prototypical Prison Policy Design Criteria." (Exhibit 17.) This policy has been revised over the years and continues to reflect CDCR and the State's policy on what will be built at each new prison. In 1988 the policy was revised to clearly reflect the reality of overcrowding in the prison system even at that time. The policy states that at Level II, III, IV and reception centers, certain functional areas of the new prison will be built to accommodate 130 percent overcrowding. Those functional areas included *only* personnel, accounting, inmate records, procurement, receiving and release and family visiting. The policy goes on to mandate that the infrastructure at new prisons, (which includes *only* water, wastewater, electrical, mechanical) will be designed to accommodate 190 percent overcrowding in celled prisons and 140 percent overcrowding in dormitory prisons. Thus, at a policy level, by default, the CDCR short-changed by at least 50% all health care related space needs.

Therefore, while the overcrowded populations of the modern facilities approach or exceed two hundred percent, and regardless of how the CDCR attempts to *characterize* the level of crowding, the available clinic space is *one half of what is necessary for daily operations*.

This CDCR policy and practice, for more than twenty years, to limit health care space, including staff offices, examination/treatment rooms and medical beds, to only the base staffing level of the institution, ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity, adversely impacts the daily medical, mental health, and dental operations at the following prisons.

1. Avenal State Prison
2. California State Prison-Calipatria
[21] 3. California State Prison-Centinela
4. California State Prison-Corcoran
5. California State Prison-Solano
6. Chuckawalla Valley State Prison
7. California State Prison-Sacramento
8. High Desert State Prison
9. Mule Creek State Prison
10. Ironwood State Prison
11. Kern Valley State Prison
12. California State Prison-Los Angeles County
13. North Kern State Prison
14. Pelican Bay State Prison
15. Pleasant Valley State Prison
16. R.J. Donovan Correctional Facility
17. Substance Abuse Treatment Facility
18. Salinas Valley State Prison
19. Wasco State Prison

2. *A Case Study of How CDCR Construction Planning Ignores the Crowding Related Clinical Space and Staffing Needs of the CDCR Health Services Program – Kern Valley State Prison.*

Kern Valley State Prison ("KVSP"), the CDCR's newest prison, opened in June of 2005, was built to a standard of "base staffing", except for water, waste water, electrical, mechanical. (Exhibit 18.) To summarize, absolutely no consideration was given to the real life impact on the prison's health care program that would result by the CDCR's plans to immediately double cell the entire prison. As a result of this policy, at KVSP the health care space on each of the four semi-autonomous facilities was limited to accommodate one Primary Care Provider's office based on the ratio of 1 doctor for every 500 inmates. Each of the four facilities was also built [22] with one Examination/treatment room, a medication distribution/sick call window, and a dental operatory/office.

Likewise, in KVSP's Central Health Care Services space the number of "infirmary beds" was determined by the prison's "design" bed capacity, even though CDCR officials knew before the construction began that the prison would be overcrowded. A Correctional Treatment Center ("CTC") was subsequently constructed in lieu of infirmary beds. KVSP has a design capacity of 2,448 inmates. Based on the CDCR's space standards this would then require KVSP to have 1 medical bed for every 125 inmates for a total of 19 beds. In fact KVSP has a total of 24 CTC beds. However, KVSP now confines not 2,448 inmates but, as of April 4, 2007, 4,952 inmates (202.3 percentage of overcrowding).

Based on the level of overcrowding at KVSP they should have at least 38 medical beds in order to accommodate the inmate-patient needs. Likewise KVSP now needs, even under the CDCR's own standards (which the Receiver finds inadequate as explained below) twice the number of clinical offices, clinical space, and infirmary beds as presently exist. In essence, KVSP was planned, designed, and subsequently constructed knowing full well that the medical, mental health, and dental space and staffing would be entirely insufficient for the prison's actual population.

3. *Millions of Dollars Allocated for Prison Health Care Space Projects and Little to Show for It.*

A summary of health care services Capital Outlay projects for the past five fiscal years is set forth in Exhibit 19. This information is significant when evaluating CDCR efforts to address the pervasive lack of health care space within its prison system. As stated above, each and every prison approved, funded and built by the State over the past twenty plus years was constructed to only accommodate "base staffing" only - except for infrastructure, water, wastewater, electrical, mechanical and certain other functions (such as receiving and release, family visiting, and accounting). The policy to build only to base staffing levels has left the CDCR in crisis regarding the clinical space needed to provide constitutional levels of access to health care.

[23] In a small effort to attempt to improve this flawed system, CDCR had obtained in the past five years approval to go forward with a limited number of health care space projects. For example, in fiscal year 2002/03 a total of 86.917 million was approved,

one-third of which was for a Ambulatory Care Center at CMF, which has in fact been completed. Many other projects, however, such as $375,000 allocated for a CTC at SQ and $1.9 million for a "Hospital" at DVI have not come to fruition. SQ does not have a CTC, nor does DVI have a hospital. Unfortunately, the CDCR construction program has a tendency to invest significant funds for the planning of projects which fail to come to fruition. For example, in fiscal year 2003/04 Ironwood State Prison ("ISP") received approved for an expenditure of $3.8 million for the completion of a CTC. These funds were in addition to $50,000 approved in 2002/03. As of this date the CTC has not been completed, as of today it does not house a single inmate or provide any health care services to inmates at ISP. Likewise, during fiscal year 2004/05 $1 million was approved for a nineteen chair dialysis center at SATF. The construction has finally, years later, been completed; however due to litigation over the contracting-out for the dialysis services, the operation of the chairs is not fully implemented. In fiscal year 2006/07 $2.5 million was approved for a "Hospital" at DVI, in addition to a fiscal year 2002/03 allocation of $1.9 million. After inquiries, the Receiver's staff were informed that this particular CDCR allocation is in fact controlled by the Department of General Services for a "seismic retrofit" of an "infirmary building." The Receiver has not approved this project; in fact, he was not aware of it until the preparation of this report, despite the allocation of $4.4 million.

In addition to the above projects, each year the CDCR has been allocated approximately $5 million for "Minor Capital Outlay" projects. These funds were allocated on a priority basis as determined by CDCR officials. Through this process, some CDCR institutions have received funds to provide additional health care space. For example, at Wasco State Prison a triple-wide trailer has been added for clinician office space, primarily utilized by mental health staff. A new health care building has been constructed next to the existing Central Health Clinic at Avenal State Prison, which, unfortunately, is located hundreds of yards of away from inmate housing [24] units. This space is primarily utilized for staff offices. At California State Prison Solano, a building was constructed on the Facility IV grounds approximately eight to ten years ago, to be utilized by mental health staff. In 2006 at R.J. Donovan custody staff moved out of their offices for use by health care staff, and a trailer has been placed in a plaza area for use as additional health care offices. At Sierra Conservation Camp ("SCC") an office has been converted into a telemedicine clinic, and at Mule Creek State Prison a former vocational area on Facility B has been converted into mental heath clinics and offices. Nevertheless it cannot be disputed that, based on the CDCR budget of the last five years, very little health care space has been added to any of the prisons which now confined at least twice as many inmates as they were designed to hold.

IV.

THE MANNER IN WHICH OVERCROWDING INTERFERES WITH THE RECEIVER'S ABILITY TO SUCCESSFULLY IMPLEMENT TIMELY PROGRAMS WHICH WILL REMEDY THE UNCONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

Overcrowding interferes with the Receiver's ability to successfully remedy the constitutional violations at issue in two significant ways: (1) substantive interference; and (2) process interference.

B. Crowding Related Substantive Interference With the Receiver's Remedial Programs.

As explained in the Plan of Action, in order to implement adequate and sustainable programs which will bring California's prisons up to constitutional standards of medical delivery, the Receiver needs to both establish the necessary correctional care infrastructure and to implement time phased, coordinated medical delivery programs. Overcrowding will inhibit this process in a number of significant ways.

1. *Crowding Related Obstacles to the Recruitment, Hiring, and Retention of Competent Medical Personnel.*

The Receiver's top priority during the next two years will involve recruitment, hiring and [25] the implementation of orientation and training programs to improve retention of necessary clinical staff (including physicians, mid-level providers, registered nurses, licensed vocational nurses), as well as support staff ranging from information technology staff to office assistants. Overcrowding adversely impacts this efforts in three ways:

a. The long-standing nature of California's prison overcrowding and the CDCR's policy of deliberately short changing the need for clinical space, combined with crisis levels of staffing shortages creates adverse barriers to the Receiver's ability to recruit and retain necessary, competent medical care staff. The Receivership will be building from "the ground up" a medical delivery system within a prison culture where what should be a relatively simple task - bringing a patient to a prison clinic - presents an almost insurmountable challenge because the number of patients who need care far exceeds the number of correctional officers available for escorts. Concerning some of the most basic elements of an adequate medical delivery system, the Receiver has found that the State's long standing acceptance of overcrowding, combined with staffing shortages, has created a culture of cynicism, fear, and despair which makes hiring and retaining competent clinicians extremely difficult.

b. The total number of clinicians and support staff needed because of the present levels of overcrowding is far above the number that would have been needed if all CDCR prisons operated at their design capacity. For the same reasons, the difficulties that would have been faced recruiting competent medical providers for the CDCR's remote prisons is also intensified, requiring necessary but costly remedial programs such as developing an air force to transport physicians out of urban areas to and from work assignments in rural prisons.[10]

c. Some of the special characteristics of California prison overcrowding will require [26] significant numbers of additional clinical personnel. For example, the number of additional clinical staff that will be needed at CIM to provide health assessments, monitor medical records, provide follow-up care, and ensure that appropriate medications are provided for more than 12,000 inmate moves each month will be significant to say the least.

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[10] In similar fashion, overcrowding will render other infrastructure programs set forth in the Plan of Action more difficult to effectuate. For example, an increase in the number of clinicians needed to care for prisoner/patients will require an increase in the number of computer terminals that will eventually be installed as part of a new information technology system. Likewise the number of medical records needs to increase as the inmate population increases, and therefore additional space must be constructed for medical records. In similar fashion the amount of medical supplies must be increased, as well a pharmacy services, etc.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention programs will increase significantly because of overcrowding. In some rural counties, the number of clinicians and support staff needed to bring local prisons up to constitutional standards may well require additional salary increases for CDCR clinicians and a resulting disruptive impact on the availability of clinicians for county and private health care programs.

2. *Crowding Related Obstacles Re the Development of Competent Managers and Executives.*

In similar fashion, overcrowding has an adverse impact on the Receiver's ability to recruit and retain competent health care managers and executives. As the Court is aware the Receiver has filed a motion to establish Receiver Career Executive Assignment ("RCEA") positions. Given on-going intensification of overcrowding, not only will the recruitment of such personnel be more difficult, but the larger the remedy, the more managers and executive who will be necessary.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention of managers and executives will increase significantly because of overcrowding.

3. *Crowding Related Obstacles Preventing the Establishment of Constitutionally Adequate Reception Center And Inter-Prison Transportation Procedures.*

The stipulated *Plata* injunction, as set forth above, calls for adequate reception center health care appraisals and the appropriate programs to protect prison medical conditions during inter-prison transportation. However the present velocity of prisoner movement into and out of reception centers as well as between prisons creates a serious obstacle to meeting these [27] objectives. Given present conditions, hundreds of additional "budgeted" correctional officers and clinical staff will be required to appropriately manage the hundreds of thousands of inmate moves that take place every year, not to mention a vast fleet of transportation vans and escort vehicles.

To summarize, the cost and duration of the remedial effort of the Receiver's programs for adequate reception centers and inter-prison transportation practices will increase significantly because of the velocity of prisoner movement in the CDCR.

4. *Crowding Related Obstacles Concerning Provisions for an Adequate Number of Health Care Beds.*

An adequate number of different levels of medical care beds are an absolutely necessary component of the Plan of Action. Overcrowding presents an obstacle to achieving this objective because, as explained by the Receiver in his bimonthly reports, three different types of additional construction will be necessary:

1. The addition of approximately 5,000 new medical beds to provide the appropriate treatment, care,

and sheltered living for CDCR prisoner/patients. To a significant degree, these beds are necessary because the CDCR has neither planned for nor provided adequate medical beds for disabled prisoners, aged inmates, and prisoners who need some form of sheltered living due to their medical or mental health conditions.

2. The construction of an as yet undetermined amount of additional clinical space at existing CDCR prisons, primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200 percent of design capacity.

3. The construction of an as yet undetermined amount of clinical offices, medical records storage areas, medical supply warehouses, etc., primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200 [28] percent of design capacity.

To summarize, the cost and duration of the remedial effort of the Receiver's construction programs will increase significantly because of overcrowding.

5. *Crowding Related Obstacles Concerning Medical Delivery Support Services.*

California prison overcrowding will also impact those elements of the Plan of Action which provide for necessary medical support services. For example, the Office of the Receiver is presently involved with a program to completely restructure the CDCR's medical contracting process. Very positive initial results have been achieved. However an increasing number of prisoners in the more remote prisons has placed a heavy burden on a very limited number of hospitals and speciality providers which in turn has created obstacles in the Receiver's efforts to achieve a more efficient, patient oriented, and less wasteful contracting process. Overcrowding presents similar obstacles to other support services. For example, the use of telemedicine should be, and will be expanded for both improved patient care and cost containment purposes. However, even the most simple of necessary expansion steps; for example, finding a room adequate for telemedicine purposes often presents an unsurmountable barrier because California's prisons were constructed without adequate clinical or office space for the numbers of inmates housed at the prison.

To summarize, the cost and the duration of the remedial effort of the Receiver's Plan to implement necessary medical care support services will increase significantly because of overcrowding.

C. Crowding Related Process Interference With The Receiver's Remedial Program.

I. *Introduction*.

Every element of the Plan of Action faces crowding related obstacles. Furthermore, overcrowding does not only adversely impact the Receiver's substantive plans, it also adversely impacts on the very process of implementing remedies because overcrowding, and the resulting day to day operational chaos of the CDCR, creates regular "crisis" situations which call for action on the part of the leadership of the Receivership and take time, energy, and person power [29] away from important remedial programs. Examples of crowding related crisis/chaos situations which impact on Receivership's remedial activities include the following.

2. *Out of State Transfers.*

The Receiver and his staff worked in a diligent manner to support the Governor's efforts to effectuate out of state transfers. This effort required the implementation of a formalized health screening process; training nursing staff on screening; allocating staff to conduct screenings; allocating staff to inspect the private out-of-state prisons where CDCR prisoners would be confined; and reviewing contracts with private prisons to ensure that mechanisms existed to provide compliance with Court orders, etc. Suddenly, however, the process was halted due to State Court decisions. Recently, however, plans for out of state transfers have begun again due to the passage of Assembly Bill 900, although questions apparently remain concerning future State Court processes. Starting, then stopping, and then restarting these support efforts must be managed in a careful manner so that the Receivership does not begin to experience the day to day chaos which afflicts the CDCR.

3. *Responding to Mission Changes and Yard Flips.*

In a similar manner, the Receiver has attempted to work with CDCR concerning the various mission changes and yard flips associated with increased overcrowding. However it has been necessary on occasion to stop changes which would have put prisoner/patients in increased jeopardy of receiving inadequate medical care. Needless to say, monitoring mission changes and yard flips has become a full time activity. It may be necessary for the Receiver to provide direct oversight over CDCR yard flips and mission changes at some time in the future should this problem further exacerbate efforts to implement the Plan of Action.

4. *Disturbances.*

CDCR reports an increasing number of overcrowding related prisoner disturbances. Most disturbances are followed by prisoner "lock downs," and on occasion the lock downs are protracted. Lockdowns call for a radically different form of medical delivery than the services provided under normal general population conditions. Under normal operating procedures, [30] inmates housed in general population leave their housing units to go to yard clinics to see medical providers, to receive medications, etc. Under lockdown conditions, clinical staff must go from cell to cell to see the prisoner/patient, or small groups or individual prisoners must be escorted by correctional officers to and from clinic areas. In either case, lockdowns inhibit the delivery of medical care and increase the staffing necessary for such care. As crowding related disturbances increase, the Receiver may need to modify the Plan of Action in order to establish special clinical and correctional officer staffing standards for those institutions which function under lockdown conditions on a regular basis.

5 *Infectious / Communicable Disease Management.*

As reported in the Fourth Bi-Monthly Report, overcrowding has increased the number and seriousness of infectious and communicable diseases, jeopardizing prisoners, staff, and the public. Thus far system wide outbreaks have been avoided, however, given the number of prisoners, conditions in gyms and hallways converted to housing units, the velocity of prisoner movement between institutions and in and out of the CDCR itself, the risk of such an outbreak cannot be underestimated.

6. *The Inability to Deliver Basic Health Care Services Due to Staffing Shortage and Increased Numbers of Inmates.*

Many CDCR prisons are unable to sustain the basic delivery of medical, mental health, and dental services because of limited staffing (clinical and custody) and an overwhelming number of prisoner/patients who require care. Every day, many California prison wardens and health care managers make the difficult decision as to which of the class actions, *Coleman*, *Perez*, *Armstrong* or *Plata* they will fail to comply with because of staff shortages and patient loads. This in turn creates crisis conditions (as described in the Fourth Bi-Monthly Report concerning Avenal State Prison) which, because it requires immediate attention, diverts the Receiver's resources from Plan of Action related activities.

7. *Class Action Coordination Issues Aggravated by Overcrowding.*

Overcrowding combined with twenty years of CDCR construction practices has created [31] competition and tensions between medical and mental health providers concerning use of clinical space. For example, because of the failure, for more than fifteen years, to provide an adequate number of inpatient beds for prisoners with very serious mental illnesses, prison CTC beds confined many patients in a mental health "crisis" creating shortages of CTC beds for medical needs which, at times, pits medical staff against mental health staff. In similar fashion, the failure by the CDCR to plan for and construct beds for aged and disabled prisoners has lead to a practice of using the CTC beds for sheltered living housing, creating similar tensions. While these issues are being addressed in monthly coordination meetings between the Receiver, the Special Master in *Coleman*, and the Court experts in *Perez*, they present another series of serious, constant problems which divert attention from Plan of Action remedial programs.

The Receiver recognizes that he is responsible for a prison medical delivery system in crisis and therefore regular crisis situations, and the appropriate response, are to be expected. However, without question, overcrowding and the resulting chaos in the CDCR has an adverse impact on the Receiver's efforts to implement the Plan of Action, and the day to day problems created by overcrowding will increase both the cost and the duration of his remedial efforts.

V.

THE IMPACT OF ASSEMBLY BILL 900

A. Introduction.

This report would not be complete without the Receiver commenting on the possible impacts of Assembly Bill ("AB") 900. A summary of the bill follows.

B. Summary of AB-900.

Section 1. Name of Act.

Names act as "the Public Safety and Offender Rehabilitation Services Act of 2007."

Section 2. Prison Construction-Phase I

Requires the CDCR to add up to 7,484 beds at 10 specified prisons.[11]

Requires the CDCR to add an additional 4,516 beds after site assessments are completed [32] at other facilities.[12]

Requires that the above beds be supported by rehabilitation programming.[13]

Declares that purpose of new beds built under this phase is to replace "temporary beds"-not to house additional inmates.[14]

Authorizes construction of reentry program facilities for up to 6,000 inmates.[15]

Authorizes construction of new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 6,000 inmates."[16]

Subjects all projects to approval and administrative oversight of State Public Works Board.[17]

Authorizes the State Public Works Board to issue bonds to finance construction.[18]

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[11] Government Code 15819.40(a)(1)(A).

[12] Government Code 15819.401(0(1)(B)

[13] Government Code 15819.40(a)(2).

[14] Government Code 15819.401(a)(3).

[15] Government Code 15819.40(b).

[16] Government Code 15819.40(c).

[17] Government Code 15819.401

[18] Government Code 15819.403.

Authorized costs for medical, dental and mental health construction are $857,100,000.[19]

Section 3. Prison Construction-Phase II

In addition to the construction required in Phase I, authorizes the CDCR to construct 4,000 beds at existing prison facilities, and requires that such beds be supported by rehabilitation programming[20]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 2,000 inmates.[21]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct reentry program facilities that will house up to10,000 inmates.[22]

Subjects all projects to approval and administrative oversight of State Public Works [33] Board.[23]

Authorizes the State Public Works Board to issue bonds to finance construction.[24]

Authorized costs for medical, dental and mental health construction under Phase II are $285,700,000.[25]

Provides that the board may not release funds for Phase II construction until a 3-member panel, composed of the State Auditor, the Inspector General and an appointee of the Judicial Council of California, has certified that 13 specified requirements have been met.[26]

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[19] Government Code 15819.403.

[20] Government Code 15819.41(a).

[21] Government Code 15819.41(b).

[22] Government Code 15819.41(c).

[23] Government Code 15819.411.

[24] Government Code 15819.413(a).

[25] Government Code 15819.413(a).

Authority provided for Phase II construction expires on January 1, 2014, but projects already commenced may be completed.[27]

Sections 4 & 5. County Jail Facilities

Relates to the financing and construction of county jail facilities, and authorizes the issuance of up to up to $750,000,000 in bonds for that purpose.

Authorizes the issuance of an additional $470,000,000 in bonds for county jail construction if the 3-member panel has certified that certain conditions have been met.

Section 6. Rehabilitation Incentives

Requires CDCR to implement a system of incentives to increase inmate participation in academic and vocational education.[28]

Section 7. Management Deficiencies

Requires CDCR to implement a plan to address management deficiencies.[29]

Section 8. Rehabilitation Plan

Requires CDCR to implement a plan to obtain additional rehabilitation and treatment services for prison inmates and parolees.[30]

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[26] Government Code 15819.417; Penal Code 7021.

[27] Government Code 15819.417.

[28] Penal Code 2054.2.

[29] Penal Code 2061.

[34] Section 9. Inmate Payments; Report to Legislature

Requires CDCR to report to the Legislature on whether existing laws related to payments to inmates released from prison are hindering the success of parolees and resulting in their rapid return to prison for parole violations.[31]

Section 10. Substance Abuse Treatment

Requires CDCR to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates.[32]

Section 11. Interdisciplinary Assessments

Requires CDCR to conduct interdisciplinary assessments for the purpose of program placement.[33]

Section 12. Day Treatment and Crisis Care for Parolees

Authorizes CDCR to obtain day treatment, and to contract for crisis care services, for parolees with mental health problems.[34]

Section 13. Prison to Employment Plan

Requires CDCR to develop an Inmate Treatment and Prison-to-Employment Plan.[35]

Sections 14 & 15. OIG: California Rehabilitation Oversight Board

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[30] Penal Code 2062.

[31] Penal Code 2713.2.

[32] Penal Code 2694.

[33] Penal Code 3020.

[34] Penal Code 3073.

[35] Penal Code 3105.

Creates within the OIG the California Rehabilitation Oversight Board, which will examine and report on CDCR mental health, substance abuse, educational and employment programs.[36]

Section 16. Reentry Program Facilities

Relates to the establishment and operation of the re-entry program facilities authorized in Phases I and II of construction described above.

[35] Section 17. Master Plan

Expands provisions defining facilities "master plan" to include the department's plans to activate or remove temporary beds in dayrooms, gyms, and other areas.[37]

Sections 18 & 19. Submission of Plans and Reports to Joint Legislative Budget Committee

Requires CDCR to submit to the Joint Legislative Budget Committee (prior to submissions of preliminary plans to the State Public Works Board) (1) a preliminary facility plan, (2) an operating cost estimate, (3) a staffing plan, (4) a plan for medical, dental and mental health care, and (5) a programming plan.[38]

Requires CDCR to submit annual and quarterly reports to the Joint Legislative Budget Committee regarding the status of funded projects, including medical, mental health and dental projects.[39]

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[36] Penal Code 6140 & 6141.

[37] Penal Code 7000.

[38] Penal Code 7003.

[39] Penal Code 7003.5.

Section 20. Communication with Local Governments

Requires CDCR to meet with representatives of cities or counties related to new permanent housing units prior to CEQA review.[40]

Section 21. [Repeals]

Section 22. Phase II Construction Panel

Creates 3-member panel charged with verifying whether certain conditions have been met before the State Board of Public Works may release funds for Phase II construction.[41]

Section 23. Temporary Construction

Authorizes use of portable or temporary buildings for housing and rehabilitation programming.[42]

[36] Sections 24-26. Out-of-State Transfers

Temporarily authorizes (until 2011) out-of-state transfers of inmates, without inmate consent.[43]

Provides that "no inmate with serious medical or mental health conditions, as determined by the Plata Receiver, or an inmate in the mental health delivery system at the [EOP] level of care or higher may be committed or transferred to an institution outside the state unless he has executed a written consent to the transfer."[44]

Section 27. Training Academy

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[40] Penal Code 7004.5.

[41] Penal Code 7021.

[42] Penal Code 10007.

[43] Penal Code 11191(a).

[44] Penal Code 11191(b).

Authorizes CDCR to establish a training academy for correctional officers in southern California.[45]

Section 28. Supplemental Infrastructure Capacity & Rehabilitation Funding

Appropriates $350,000,000 from the General Fund to CDCR for capital outlay to renovate, improve, or expand infrastructure capacity at existing prison facilities and to supplement funds for rehabilitation and treatment of prison inmates and parolees.

Section 29. Urgency Statute

Provides that Act goes immediately into effect.

C. CDCR Does Not Have An Adequate Plan to Create "In-Fill" Beds With the Necessary Support (Including Health Care Clinic) Space.

1. *Introduction.*

Following a first review by his staff of AB 900 and an evaluation of CDCR plans to implement AB-900, the Office of the Receiver can provided initial findings concerning possible impacts of the bill, as set forth below.

2. *Inadequate Space Allocations For Health Care Services.*

The CDCR's Infill Bed Plan is included as Exhibit 20. A summary of the space proposed to be allocated for health care space (medical, mental health, and dental) is attached as [37] Exhibit 21. As is apparent from the summary, the clinical space allocated to different prisons are wildly disparate, and in many cases obviously inadequate. For example, for clinical purposes, the proposed administrative segregation unit at Avenal (190 beds) is allocated 2,970 square feet of space, while the administrative segregation unit at Calipatria (190 beds) is allocated 2,127 square feet of space and the administrative segregation unit at Centinela (190 beds) is allocated 1,779 square feet of space.[46]

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[45] Penal Code 13602.1.

The Receiver has not been informed concerning what elements of the January 2007 Infill Bed Plan will be utilized under AB-900. Regardless, there exists a fundamental error in the manner in which CDCR has traditionally approached health care clinic construction (in addition to the past practice of allocating only one-half as much space as actually necessary given the real prisoner population intended for new prisons). CDCR allocates *space only*, ignoring the real life differences in clinical requirement based on the characteristics of the patient population, security level and escort officers requirements, the need for clinical privacy, equipment requirements, and other critical factors.

In terms of all future clinic construction, the Receiver believes that, consistent with standards promulgated by the National Commission on Correctional Health Care ("NCCHC") and because of the vast differences among facilities, design, number of facilities in any given prison complex, and the age of buildings, rather than specifying square footage adequate space will be based on a number of different standards including the type of service provided, the need for pharmacy services, equipment need, inmate classification, supply needs, examination services, etc. (Exhibit 22.)

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[46] In addition to requiring medical and dental treatment, inmates confined to administrative segregation require heightened levels of mental health care and monitoring. Historically, a very high percentage of CDCR suicides take place in administrative segregation housing units. Therefore it is essential that the planning and construct of administrative segregation housing provides for enhanced space for mental health clinical interview and staff offices. The January 2007 Infill Plan appears to ignore this.

3. *Inadequate Overall Health Care Space Allocations.*

It must be noted that the existing CDCR construction related space allocations for clinics [38] and clinical office space are inadequate. For example, the CDCR allocation of 60 square feet for a nursing station, given the need for examination equipment, escorts, records, etc. is grossly inadequate. Exhibit 23 provides a summary of certain of the major shortfalls of current CDCR allocations.

4. *Conclusion.*

The existing CDCR Infill Bed Plan, if allowed to be implemented without oversight by the Receiver, the Special Master in *Coleman*, and the Court representatives in *Perez* and *Armstrong* will jeopardize prisoner/patient care and have a serious adverse impact on the Receiver's ability to implement the Plan of Action in a timely and cost effective manner.

D. AB-900 Will Not Reduce the Number of "Temporary ("Ugly") Beds at the Ten CDCR Prisons Subject to AB-900.

Phase I of AB-900 identifies ten [39] prisons that will have a total of 7,184 beds added to their design capacity. The stated intent of AB-900 is to build new prison capacity which will "replace the temporary beds currently in use, and they are not intended to house additional inmates." AB-900 defines temporary beds as "those that are placed in gymnasiums, classrooms, hallways, or other public spaces that were not constructed for the purpose of housing inmates."[47] The CDCR, in its Master Bed List refers to these same beds as "non-traditional overcrowding beds."

In order to determine if AB-900, if fully implemented as written will reduce the existing and overcrowding levels at these ten prisons, Exhibit 25 was created. The first column of this exhibit lists the ten prisons as specified by AB-900 followed by the current security level and number of "temporary beds". The third column sets forth the CDCR's proposed Infill Bed Plan for each of the ten prisons by security level. For example, at Pleasant Valley State Prison there currently exists 774 Level III "temporary" beds and 150 Level IV "temporary" beds. However, the CDCR Infill Bed Plan proposes to add only 600 Level II beds.

From what the CDCR has provided, it appears that the total number of beds that will be "replaced" as required by AB-900 will be limited to 472 reception center beds. Eight of the ten prisons will have zero temporary beds replaced based on CDCRs In-Fill Bed Plan. Based on the fact that only 472 reception center temporary beds will be taken down per AB-900, the remaining 4,280 exiting temporary beds at these ten institutions will remain filled with inmates.

It may be possible to fill proposed Infill beds at these ten prisons with inmates from other prisons. However in Phase I of AB-900 the vast majority of the 7184 new beds being created are Level II beds (4,300 beds). The movement of Level II inmates from other institutions' "temporary beds" into the new housing units may have a positive impact on the sending institutions, *but only if they are then prohibited from back filling those temporary beds.* However considering the CDCR's history and practice of filling all available beds, coupled with the fact that AB-900 does not prohibit such action, we should anticipate that CDCR will continue to house inmates in these temporary beds even *after inmates are moved to the ten institution's new housing units.* In reality, therefore, AB-900 will serve only to increase the number of prisoner/patients who will required medical, mental health, and dental care.

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[47] A summary of "temporary beds," also known as "ugly beds" is attached as Exhibit 24.

E. AB-900 Does Not Address The CDCR's Most Serious Need For Additional Prison Beds.

The Infill Bed Plan proposes total (Phase I and II) addition of 16,238 beds, of which 9,440 are Level II beds, which will have some impact on the severe crowding at lower level prisons. The Infill Bed Plan, however, does nothing to address the serious levels of crowding within the CDCR's most dangerous high security prisons.

The top chart in Exhibit 26 summarizes the CDCRs projected Male population needs by security level from fiscal year 2007/08 through fiscal year 2011/12.[48] The first column identifies the fiscal year, the second through the eighth columns identifies the security level, and the last column is the projected grand total of Male inmates. The CDCR projects that the Male population for all security levels except Protective Housing Unit will increase over the next five fiscal years. The greatest increase is projected to be at security level IV with 3,830 additional [40] Male inmates to be accommodated within the existing overcrowded institutions. Level IV prisoners are considered by the CDCR to be the most dangerous in terms of escape risk and potential for in-prison misbehavior.

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[48] This information was obtained from the CDCRs Spring 2007 Adult Population Projections 2007-2012 report.

The lower chart compares *only* the additional projected Male population needs with the CDCRs proposed In-Fill Bed Plan. Based on this comparison, there appears to be a significant disconnect between the CDCR's projected housing needs, especially in its most dangerous prisons, and what the CDCR is planning to build. For example, CDCR projects an increase of 3,840 Level IV inmates while the CDCR's Infill Bed Plan does not include a single Level IV bed. The same is true for Security Housing Unit (SHU) inmates with a projected increase of 425 inmates with no plan to increase the SHU beds by even one bed/cell.

Given current levels of overcrowding at two of the CDCR's Level IV and SHU institutions, a serious need for additional Level IV and SHU beds is clearly demonstrated. For example, as of April 4, 2007 Pelican Bay State Prison ("PBSP"), a SHU and Level IV institution was operating at 154.5% of design capacity. Salinas Valley State Prison ("SVSP") another Level IV institution as of April 4, 2007 was operating at 206.8% of design capacity. The failure to plan for additional Level IV beds based on the current level of overcrowding and the projected increase of Level IV and SHU bed needs, will create additional severe overcrowding within the CDCR's most dangerous and difficult to manage prisons at this time. If overcrowding intensifies in the CDCR's highest security institutions, the Receiver's effort to implement the

Plan of Action will require more time and additional funding.

F. AB-900 Re-Entry Facilities.

AB-900 proposes to site and construct numerous re-entry facilities throughout the State. Each of those facilities will require clinical staff to provide intake and exit health care assessments. In addition, each facility will require on-site health care staff to delivery needed care. In essence AB-900 calls for a new set of institutions to be included in the existing Federal Court remedial plans. Given the record in this case, the Receiver must assume that adding more CDCR institutions will increase the cost and the time necessary to implement the Plan of Action.

[41] G. Staffing.

It is easy to talk of constructing prisons and jails. It is more difficult and expensive to staff correctional institutions with the appropriate clinical personnel and correctional officers. AB-900, however, is silent about how the jails and prisons beds cited in the bill will be staffed and managed. Unless and until adequate staffing is provided, the Receiver anticipates that the additional beds proposed in AB-900 institutions will increase the cost and the time necessary to implement the Plan of Action.

VI.

CONCLUSIONS

The Receiver summarizes his best assessment of the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations as follows:

1. The Receiver's Plan of Action will work. Failure is not an option. Over time the CDCR's medical deli-

very system will be raised to constitutional levels. However, the time this process will take, and the cost and the scope of intrusion by the Federal Court cannot help but increase, and increase in a very significant manner, if the scope and characteristics of CDCR overcrowding continue. For example, the Receiver can, over time and with great expense, develop a reception center medical delivery system that will appropriately handle the more than 11,000 prisoner moves into and out of CIM each month. The cost of such effort, however, may all but bankrupt the State of California and create a medical delivery problem in Riverside and San Bernardino counties because there may not be enough competent clinicians to both provide medical care for an unlimited number of State prisoners and for the public also. Thus, when the Court considers the issue of intrusion relative to controlling overcrowding, it should also consider the scope of intrusion that will be necessary to provide constitutionally adequate medical care in California's prisons if overcrowding is not managed.

2. The manner by which overcrowding is managed will have a fundamental and perhaps irrevocable impact on the Plan of Action. For example, if the State's response is limited to [42] effectuating out of state transfers, and thereafter filling empty beds behind departed prisoners, the overcrowding related challenges to the Plan of Action will only increase and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue. Likewise, if the State charges off to construct infill beds in remote locations without adequate support services space, including adequate clinical space, overcrowding related challenges to the Plan of Action will only increase, and as a result, it will take the Receiver longer and it will cost more to correct the

constitutional violation at issue. Finally, unless steps are taken to stop the revolving door of a failed parole system and thereby manage the out-of-control number of prisoner moves, the churning related challenges to the Plan of Action will continue and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue.

3. Finally, and perhaps more important, it is critical that the Court and counsel understand that the motion for a three judge panel can be separated and distinguished from the fundamental challenges faced by Receivership. While the attorneys for plaintiffs have filed three separate requests for a three judge panel in three different cases, it is important to emphasize that even if a three judge panel is appointed and even if the California prison system is, over time, capped, and even if its population is reduced by, for example, twenty-five percent (thereby releasing from existing housing units as many as 42,500 prisoners), the challenges faced by the Receiver and the Courts in *Armstrong*, *Coleman*, *Perez*, and *Plata* would remain a daunting one: to provide constitutional levels of prison health care for 125,000 prisoner/patients who will remain confined thirty-three inadequately constructed prison that function far above their correctional design capacity. Thus, even when assuming some form of population management, it will take years of effort and significant State resources to address the prison health care problems faced by the Federal Courts in California at this time.

To summarize, those who believe that the challenges faced by the Plan of Action are uncomplicated and who think that population controls will solve California's prison health care problems, are simply wrong. Population limits may help effectuate a more timely and cost effective remedial process. However, the cure to existing health care problems will be difficult [43] and costly to implement, regardless of population control efforts.

4. The following remedial actions in *Plata* are warranted now:

a. The CDCRS "in-fill" bed project, if allowed to proceed without oversight by the Receiver may well jeopardize prisoner patient health care. The Receiver recommends that the Court issue an order compelling the Secretary of the CDCR to file, within fifteen days, a report to this Court and to the *Armstrong*, *Coleman*, and *Perez* Courts concerning all aspects of the "infill" project, including all studies and expert reports that have been conducted relative to the issue of whether adequate space exists to construct additional non-medical beds with the appropriate support services, including clinical space. The Receiver has reviewed prior CDCRS submissions and recommends that the order should specifically require an executive summary of all proposed infill programs not to exceed ten pages.

b. The CDCR's long standing failure to hire an adequate number of correctional officers jeopardizes prisoner patient heath care. The Receiver recommends that the Court issue an Order to Show cause compelling the Secretary of the CDCRS to file, within fifteen days, a response as to why the Receiver should not begin to provide direct oversight over the CDCR's correctional officer recruitment and hiring program.

c. The Office of the Governor will be filing responsive pleadings to the Court's February 15, 2007 Order concurrently with this filing by the

Receiver. The Receiver recommends that the Court consider whether the Governor should create his Plan of Action concerning how California will address the serious correctional problems afflicting the CDCR. Thus far, the Governor has worked to encourage the initial successes of the Receivership; however, for the Receiver's Plan of Action to be implemented in the most timely and cost effective manner possible, the State should develop a CDCR Plan of Action. As pointed out in this report, the CDCR's lack of planning, the day to day chaos within the CDCR, and its long standing failure to effectively perform basic correctional functions including prison construction and correctional officer hiring jeopardize prisoner patient medical care. The development of and adherence to a complementary correctional Plan of Action will enhance efforts by the Federal [44] Courts to bring California's prison health care up to constitutional standards of access and quality and will thereby hasten the return of the system back to the State.

Dated: May 14, 2007.

/s/ Robert Sillen
Robert Sillen
Receiver

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P (E.D.Cal.)

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH (N.D.Cal.)

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 05-05241 JSW (N.D.Cal.)

CARLOS PEREZ, *et al.*,
Plaintiffs,
vs.
JAMES TILTON, *et al.*,
Defendants.

ORDER

[2] The Receiver in *Plata*, the Special Master in *Coleman*, and the Court Representatives in *Perez* have presented to the judges in the above-captioned cases six agreements that they have reached during the coordination meetings that they have held to date. The agreements, which are attached to this order, are presented to the undersigned for review and approval. The undersigned are aware that there is a hearing scheduled on June 1, 2007 in the *Perez* matter with respect to increasing dental salaries and a hiring and management plan. All parties are advised that this hearing shall go forward and the motion shall be considered on its own merits.

Good cause appearing, IT IS HEREBY ORDERED that the parties in the above-captioned cases are granted until June 15, 2007 to file and serve a response to the request for court approval of these agreements. Any response to this order shall be filed in each of the above-captioned cases and served on all of the parties to all of the cases and on the Receiver, the Special Master, and the Court Representatives. Thereafter, the request for approval of the agreements will be taken under submission for individual and joint consideration by the undersigned.

DATED: 5/29/07

/s/
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

DATED: 5/29/07

/s/ Thelton E. Henderson
THELTON E. HENDERSON
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

DATED: 5/29/07

/s/
JEFFREY S. WHITE
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[3] CIM-GACH

The Receiver and the Special Master have agreed that the General Acute Care Hospital (GACH) license at the California Institute for Men (CIM) should be suspended. The physical unit will remain open and house 40-45 Mental Health Crisis Beds (MHCBs). Staffing levels will not change for mental health care.

The Receiver and the Special Master are concerned that defendants will not be allowed to operate MHCBs in unlicensed facilities. A state court decision, *Budd, et al. v. Cambra, et al.*, Case No.319578, required the California Department of Corrections and Rehabilitation (CDCR) to bring its correctional treatment centers (CTCs) into compliance with state law licensing requirements. Counsel for the parties may argue that *Budd* requires defendants to provide inpatient health services to inmates presently below an acute level of care in a licensed facility.

The *Coleman* Special Master has agreed to explore whether a CTC license is necessary to operate a MHCB. if such a license is necessary, the Special Master will seek an emergency order from the *Coleman* Court to allow for the operation of the MHCBs at CIM, as was done in the case of CMC.

On May 1, 2006, when faced with a MHCB crisis, the *Coleman* Court ordered the establishment of 36 MHCBs in the former locked observation unit (LOU) at California Men's Colony (CMC). The LOU at CMC had been closed and reopened as an outpatient housing unit, in light of *Budd*. The *Coleman* Court stated that until further notice and on a temporary emergency basis "defendants shall not close any intermediate inpatient bed or mental health crisis bed on the basis of state licensing requirements without approval of the special master." In its order, the Court stated that "it is essential to provide immediately mental health crisis beds to critically ill inmates in the CDCR . . . Under present circumstances, state licensing requirements must temporarily give way to measures necessary to remedy the Eighth Amendment violations that remained unsolved in this action." (See *Coleman* Order dated May 1, 2006, document number 1800).

The purpose of the order was to provide, on an interim basis, sufficient temporary MHCBs until the 50-bed MHCB projects at CMF and CMC were completed. Allowing the license to remain for the 40-45 agreed upon MHCBs at CIM-GACH could possibly avoid *Budd*-driven complications.

[4] Contracts

Effective April 17, 2006 the Receiver assumed responsibility for overseeing the State's compliance with the Federal Court's mandate (1) that "all current outstanding, valid, and CDCR-approved medical invoices" be paid within 60 days of March 30, 2006; and (2) that under the direction of the Receiver, the CDCR and State entities responsible for contracts develop and institute health care-oriented policies and standards to govern the CDCR medical contract management system considering both the need for timely on-going care and the fiscal concerns of the State.

The Receiver has created a Contract Pilot Unit that includes personnel from CDCR's Office of Business Services, staff who now report directly to the Office of the Receiver through the *Plata* Support Division. In addition, selected personnel from the Health Care Operations Support Section of the DCHCS, as well as personnel from the Health Care Cost and Utilization Program have been added to the Pilot, as have staff at four prisons (San Quentin State Prison, Pelican Bay State Prison, California Medical Facility, and the Central California Women's Facility) and two Regional Accounting Offices (North Coast and Corcoran). Upon successful completion of the Pilot, the new streamlined contract procurement and payment policies established by the Pilot will be adopted by all CDCR facilities according to a time-phase schedule which has not yet been determined.

These new policies are supported by a newly created, computerized Health Care Document Management System (HCDMS) which will manage all medical contracts, replacing the former paper based system. The HCDMS has three primary components in that it:

- Assists CDCR staff by utilizing uniform contract templates for the creation of contracts that do not permit deviation from health care policies and standards.
- Stores all health care contracts in a database accessible to all authorized users.
- Establishes an effective payment system designed to receive, store and communicate invoices electronically. By computerizing all contracts and invoices, the HCDMS eliminates the time spent transferring paper copies throughout CDCR and electronically prints invoices with their governing contracts for faster information retrieval.

The Receiver will assume responsibility for direct oversight of the contracting functions for medical, dental and mental health programs. The *Coleman*

Special Master and *Perez* Court appointed experts will participate in the design and implementation of periodic reports to monitor the status of contract management. The *Coleman* Special Master and *Perez* Court appointed experts, along with defendants' mental health and dental administrators, will also be involved in establishing standards (including proposed rates of reimbursement for contract clinicians) for registry contracts within their respective areas of concern.

[5] Credentialing

Credentialing is the process of obtaining, verifying, and assessing the qualifications of an applicant to provide patient care, treatment, and services in a California Department of Corrections and Rehabilitation (CDCR) medical facility. The credentials review process is the basis for making appointments to the clinical staff; it also provides information for granting clinical privileges to licensed independent practitioners. The purpose of verifying credential data is to ensure that the individual requesting privileges is in fact the same individual that is identified in the credentialing documents. In addition, it is to ensure that the applicant has attained the credentials as stated, that the credentials are current, and that there are no challenges to any of the credentials.

Privileging is the process used to grant to a specific practitioner the authorization to provide specific inmate-patient care services. Privileging ensures that the individual is capable of providing those services in accordance with the standard of care of the Division of Correctional Health Care Services (DCHCS).

These processes are performed at time of appointment and at least every two years to ensure the credentials remain current. Final approvals of credentialing/privileging are made by the chief of either the medical, dental or mental health programs as appropriate.

These functions are currently performed by the Division of Correctional Health Care Services Pre-Employment Credential Unit which consists of three positions. These positions are all classified as Staff Services Analyst/Associate Governmental Program Analyst. The Receiver will assume responsibility for the credentialing/privileging functions for the medical, mental health, and dental programs to include direct oversight of the Pre-Employment Credential Unit.

The *Coleman* Special Master and the *Perez* Court experts will consult with the defendants' mental health and dental administrators and will participate in, and have final approval of, the establishment of credentialing/privileging standard within their respective disciplines.

[6] Hiring

The Receiver has established the *Plata* Support Division to provide administrative support for the reform initiatives he has established. The Personnel Services and Staff Development Section have implemented new recruiting and hiring programs to improve the retention of medical staff (including creating new or revising current job classifications, implementing salary increases for specified classifications, designing new hiring and on-boarding processes, establishing training programs for institution personnel staff and for new supervisors, and improving the credentialing process of medical staff). This section has assumed full responsibility for all human resources-related functions for the *Plata* classifications, removing those functions from the CDCR's Support Services Division.

The *Plata* Workforce Development Section is working to recruit and hire additional medical professionals to fill the many vacancies that exist throughout California's prison system. To ensure that proactive steps are taken on a daily basis to fill medical professions vacancies in an expeditious manner, a pilot for "one-day hiring" was rolled out February 22, 2007.

The Receiver will assume responsibility for hiring of medical personnel only. However, *Plata* Support Division staff will provide consultation to the *Coleman* Special Master and *Perez* Court experts, as well as to defendants' mental health and dental administrators, on recruitment and hiring practices.

The Receiver will consider assuming responsibility for hiring dental and mental health personnel only after:

- The *Plata* hiring programs are fully implemented and the future workload has been assessed.

[7] IT

The objective of the Receiver's long term IT program is to construct and support the California Correction Health Care Information System based on the importance of "correct data at the point of care." The core design is based on an Electronic Medical Record (EMR) for each inmate/patient. The EMR will be paperless, medical information gathered in one location for physicians and clinicians to access, at various locations, and thereby enable them to make informed and safe medical decisions. All data obtained will be patient centric to allow for an "Information at the Point of Care" system.

To support the establishment of an EMR, a foundation will be formed. It will contain four components: 1) technical infrastructure, 2) clinical infrastructure, 3) data infrastructure, and 4) operational infrastructure. The technical infrastructure will provide a high-speed connection to a network of multiple sites. The clinical infrastructure will provide a repository of standardized data through verifiable data processes and compile medical data across all compliant data sources into a unified database that can be used to generate information valuable for patient care and healthcare management. The data infrastructure will implement a secure clinical web-based portal tool that allows clinical staff appropriate access to verified and standardized patient data at the point of care or clinical work areas (i.e. university hospitals, local specialty care centers). The operational infrastructure will provide clinical informatics with a near zero fault tolerance system to support various operations (i.e. Maxor Pharmaceuticals). Upon this foundation, the EMR will be supported by uniform clinical data provided by two types of clinical information systems: 1) clinical business systems and 2) clinical systems. The Clinical Business System will sustain such areas as access tracking, scheduling, correctional interface, clinical resource scheduling, clinical contracting, credentialing, and CME (define acronym) verification. The clinical systems will sustain such areas as laboratory, radiology, pharmacy, clinical department workflow, telemedicine, digital imaging, dental systems and mental health systems.

Based on these systems the EMR will facilitate:

- a clinical data warehouse
- views on data - patient, clinician, administrator portals and reports
- integrated patient care at the a regional level
- clinical/case management and outcome reporting
- chronic disease registries
- enterprise wide/common scheduling
- supported clinical decisions
- cost effective and timely patient-centered care
- telemedicine delivery

The Receiver will assume responsibility for implementation of the long term IT program to include the medical, dental and mental health programs. The *Coleman* Special Master, the *Perez* Court experts, and defendants' mental health and dental administrators will be kept informed of the progress of this long range project and will provide necessary input concerning mental health and dental clinical data needs.

Telemedicine is a critical component of the Receiver's plan to bring the California Prison Health Care system to a constitutional standard. The Receiver has determined [8] that the current Telemedicine program managed by the Division of Correctional Health Care Services (DCHCS) has been mismanaged resulting in lack of utilization and understaffing. The Receiver will assume responsibility for the telemedicine program serving the medical, dental and mental health programs to include direct oversight of the office of telemedicine services comprised of eight personnel (4 RNs, 2 SSAs, 1 HRT II, and 1 TCA II). The *Coleman* Special Master will consult with defendants' mental health administrators to assist in establishing clinical guidelines for the mental health component of the telemedicine program.

The Receiver will assume responsibility to support the current Mental Health Tracking System until it can be integrated into the long term IT program.

The *Perez* Court experts will meet with the Receiver's IT staff to determine:

- Whether the "intermediate" dental IT system ordered by Judge White can be implemented within the prescribed time constraints?
- If it cannot be implemented as directed, whether the Court experts should seek a modification of the court order to integrate the dental IT system within the infrastructure and timeline of the long term IT program?

[9] Pharmacy

In late 2006 the Office of the Receiver entered into an agreement with Maxor National Pharmacy Services Corporation (Maxor) to provide pharmacy management consulting services. That contract was effective January 1, 2007. On March 30, 2007 the Receiver's request for an order *nunc pro tunc* to waive state law applicable to this agreement was granted by the Court.

Maxor has developed a "road map" designed to restructure and manage a constitutionally adequate pharmacy services delivery system. The primary objective of the road map is to produce sustainable, patient-centered, outcome-driven processes, with the ultimate goal of creating a CDCR-managed and operated "best practice" pharmacy system within three years. The road map consists of the following interior goals for pharmacy operations that will serve medical, dental and mental health delivery systems:

- Develop meaningful and effective centralized oversight, control and monitoring of the pharmacy services program.
- Implement and enforce clinical pharmacy management processes including formulary controls, Pharmacy and Therapeutics (P&T) committee, disease management guidelines, and the establishment of a program of regular institutional operational audits.
- Establish a comprehensive program to review, audit and monitor pharmaceutical contracting and procurement processes to ensure cost efficiency in pharmaceutical purchases.
- Develop a meaningful pharmacy human resource program that effectively manages staffing, compensation, job descriptions, competency, performance, assessment, discipline, training, and use of the workforce including temporary employees and non-pharmacist staff.
- Redesign and standardize overall institution level pharmacy drug distribution operations for inpatient and outpatient needs. Design, construct and operate a centralized pharmacy facility.

- Design and implement a uniform pharmacy information management system needed to successfully operate and maintain the CDCR pharmacy operation in a safe, effective and cost efficient way, based on a thorough understanding of a redesigned work process.
- Develop a process to assure that CDCR pharmacy meets accreditation standards of the designated healthcare review body (NCCHC or ACA) and assist in obtaining accredited status.

The Receiver through Maxor will assume oversight of pharmacy operations serving medical, dental and mental health programs. *Coleman* and *Perez* Court appointed experts will consult with defendants' mental health and dental administrators and participate in the P&T committee in development of formularies within their respective areas of concern. Maxor will provide periodic reports to the Receiver, the *Coleman* Special Master and the *Perez* Court appointed experts concerning road map compliance.

California
Prison Health Care
Receivership Corporation
(CPR, Inc.)

Prison Medical Care System Reform

Plan of Action

November 2007

Revision 11/15/07

Introduction

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[1] INTRODUCTION TO THE RECEIVER'S NOVEMBER 15, 2007 PLAN OF ACTION

A. *Overview of the November 15, 2007 Iteration of the Receiver's Plan of Action*

The Receiver's November 15, 2007 Plan of Action (POA) submission is comprised of six components: (1) Introduction; (2) Executive Summary of the Receiver's Initiatives for November 15, 2007 through November 15, 2010; (3) two charts setting forth Initiative objectives that are: expected to be piloted or achieved within 6 months, 12 months, 24 months and 36 months; (4) the modified POA; (5) narratives concerning each of the Receiver's 22 Initiatives, including text indicating those objectives that are expected to be piloted or achieved within 6 months, 12 months, 24 months and 36 months; and (6) an Appendix of documents relevant to the Initiatives.

In May 2007, the Receiver submitted his first POA, an initial roadmap for the change necessary to bring the delivery of medical care in California's prisons up to Constitutional levels. That initial POA, drawing upon established conceptual frameworks articulated by the Institute of Medicine and the Malcolm Baldrige National Quality Program, identified seven primary goals and roughly 200 corresponding objectives, as well as setting forth a number of Receivership priorities for the near future.

The Receiver continued to inform the Court about the status of his priorities in the Quarterly Reports. As promised by the Receiver, this second iteration of the POA provides far more specific information about implementation of the POA, focusing attention upon his key priorities, which are presented to the Court in the form of 22 Initiatives. For each such Initiative, background information is provided (including, in many cases, reference to the Court's Findings of Fact and Conclusion of Law re Appointment of Receiver filed October 3, 2005), the current status of the Initiative is explained, an explanation is provided concerning Initiative objectives for 6 months, 12 months, 24 months and 36 months intervals, and relevant metrics relating to the Initiative are established (if possible). Each narrative concludes with an explanation of the potential barriers to successful implementation.

B. *The Receiver's Thirty-Six Month Initiatives*

The Initiatives are set forth below. The Receiver, working in conjunction with his staff, with CDCR medical providers, and with the consultants he has retained, selected the Initiatives based on two maxims: "Crawl, walk, run" and "First things first." Each Initiative has broad systemic impact, and many relate to one another as precursors to future systemic change. Each of these Initiatives will require extraordinary efforts to implement in a timely and effective manner.

1. Clinical Initiatives
    a. Medical Staff Professional Development (POA Objective A.7)
    b. Nursing Executive Leadership Initiative (POA Objective A.7)
    c. Healthcare Orientation, Nursing Preceptor Program, and Provider Proctoring Program (POA Objective A.8.1 and A.8.5)
    d. Nursing Medication Delivery Process Redesign (POA Objective B.8)
    [2] e. Asthma Initiative (POA Objective B.3.1)
    f. Emergency Response Initiative (POA Objective B.1.1)
2. Clinical Operations Initiatives
    a. Clinical Quality Measurement and Evaluation Initiative (POA Objective C.2, C.6 and C.8)
    b. Clinical Support Services Initiative (POA Objective B.12)
3. Construction Initiatives
    a. San Quentin Construction Initiative (POA Objective F.2)
    b. 5,000 Prison Medical Bed Construction Initiative (POA Objective F.3)
    c. Facility Improvement Construction Initiative (POA Objective F.1)

4. Custody Access Initiative (POA Goal E)
5. Administrative Initiatives
    a. Out-of-State, Community Correctional Facilities, and Re-entry Oversight Initiative
    b. Contract and Invoice Processing Initiative (POA Objective A.4 and A.6)
    c. Fiscal Services Initiative (POA Objective A.2.4 and A.2.5)
    d. Personnel Services Initiative (POA Objectives A.7, A.8, and A.8.5.3)
    e. Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative (POA Objective C.3)
6. Information Technology Initiative (POA Goal D)
7. Maxor Pharmacy Services Initiative (POA Goal B.8)
8. Pilot Project Initiatives
    a. San Quentin Project Initiative (POA Objective B.2)
    b. Specialty Services Pilot at California State Prison—Los Angeles County and California Correctional Institution (POA B.2 and B.3)
9. Class Action Coordination Initiative

As stated above, the Receiver has continued to inform the Court of his priorities in his Quarterly Reports. Note the following: in the list of 36-month priorities outlined in the Sixth Quarterly Report (*see* Sixth Quarterly Report at 6:9 - 9:27), the following initiatives were organized under other initiatives:

1. Restructuring of the credentialing process is included in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Sixth Quarterly Report; previously listed as item 9).
2. The pilot project for joint clinical/internal affairs investigations is included in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Sixth Quarterly Report; previously listed as item 10).
3. [3] Implementation of a clinical peer review-based program to evaluate clinical competency is encompassed in the Clinical Quality Measurement and Evaluation Initiative (*see* page 8 of the Receiver's Sixth Quarterly Report; previously listed as item 12).
4. Establishment of an Office of Evaluation, Measurement and Compliance is encompassed in the Clinical Quality Measurement and Evaluation Initiative (*see* page 9 of the Sixth Quarterly Report; previously listed as item 16).

One new Initiative was not included in the Sixth Quarterly Report but has been added: Creation of a Clinical Support Services Unit within the Plata Support Division to manage statewide radiology services, clinical laboratory services, telemedicine service, and a health information management system. *See* Clinical Operations Initiative.

C. *Conceptual Basis for the Receiver's November 15, 2007 Iteration of his Plan of Action*

The conceptual basis for this iteration of the POA remains the same as that set forth in May 2007. The overall goals of a constitutionally-adequate prison medical care system are to reduce unnecessary morbidity and mortality, improve inmates' health status and functioning, coordinate care with mental health and dental, and protect public health. The Receiver must create a sustainable, evidence-based, cost-effective system of care that is continually monitored and revised to meet those overall goals.

Two sources of guidance have been particularly useful in framing this plan, the Institute of Medicine and the Malcolm Baldrige National Quality Program, both of which support healthcare's increasing emphasis on safety and high reliability.

Institute of Medicine

The conceptual basis for the Receiver's Plan of Action draws heavily from the experience of free-world, mainstream initiatives launched to move American health care from fragmentation and error to safety and reliability. The Institute of Medicine (IOM), a component of the National Academy of Sciences created in 1970 to provide unbiased evaluations of American health care, has documented many of these advances. In response to the quality crisis within mainstream American health care, the IOM has promulgated a widely-accepted conceptual framework[1] that applies within corrections as well. According to the IOM, personal health care in any setting should be safe, effective, patient-centered, timely, efficient, and equitable. To achieve these goals, the IOM recommends six essential organizational supports for change:

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[1] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

1. Redesign of care processes based on best practices.
2. Information technologies for clinical information and decision support.
3. Knowledge and skills management.
4. Development of effective teams.
5. [4] Coordination of care across patient conditions, services and settings over time.
6. Incorporation of performance and outcome measurements for improvement and accountability.

The IOM has demonstrated that these strategies will transform medical care delivery systems. In the 1990s, for example, the Veterans Health Administration used integrated, system-level strategies to move from a culture of low expectations to performance far exceeding the national average. Isolated interventions, such as educating or even replacing groups of physicians or nurses, would not have yielded the same progress.

The IOM's formulation of goals and strategies is reflected in the Plan of Action. The opening sentence of the 2001 IOM report resonates with California's prison medical care crisis: "The American health care delivery system is in need of fundamental change." It is important to remember, however, that the systems described as "dysfunctional" by the IOM have been vastly superior to California's prison medical care system. It is one thing to lack an electronic health record; it is another to try running a patient scheduling system on hundreds of unconnected, unsupported desktop computers by having staff hand-carry data drives from one computer to another in sequence. It is one thing to bemoan a lack of teamwork among clinicians; it is another to work in a system that has traditionally hired any physician with "a license, a pulse, and a pair of shoes," as described in the Court's February 14, 2006 "Order Appointing Receiver." Even worse, some clinicians of that caliber managed to migrate into positions of local leadership. Because of the abject levels of dysfunction and chaos in hiring, review, promotion, and discipline, for example, the Receiver's team has spent countless hours on personnel issues, working to establish the infrastructure required for the most basic of quality initiatives.

Baldrige Systems Framework

The Malcolm Baldrige National Quality Program was created by Congress in 1987 and is administered by the federal National Institute for Science and Technology. The seven categories of the Baldrige Health Care Criteria for Performance Excellence[2] complement the IOM framework, providing an organizational foundation for the Plan of Action:

1. Leadership
2. Strategic planning
3. Focus on patients and other customers
4. Measurement, analysis, and knowledge management
5. Workforce focus
6. Process management
7. Results

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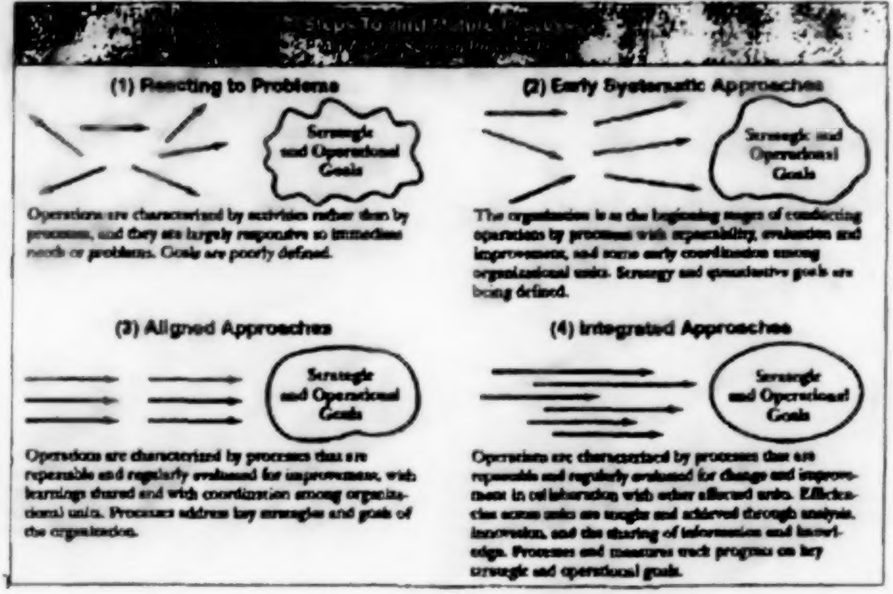
[2] Baldrige National Quality Program. *Health Care Criteria for Performance Excellence*, 2007.

The Baldrige framework highlights the leadership and personnel dimensions that have captured so much of the Receiver's attention. The November Plan of Action includes multiple initiatives regarding recruitment, hiring, orientation, professional development, and executive leadership. A motion to reform the physician disciplinary process while preserving physicians' [5] due process rights is pending before the Court. In addition, the Receiver has begun to identify, within existing staff and new recruits, the transformational leaders who can focus the system on new goals and strategies.

The Baldrige framework also highlights the importance of moving from crisis management to alignment and integration of core operations, shown diagrammatically below. Alignment requires "a common understanding of purposes and goals." Plans, processes, information, resource decisions, actions, results, and analyses should all support those goals. "Integration goes beyond alignment and is achieved when the individual components of a performance management system operate as a fully interconnected unit."


(1) Reacting to Problems
Strategic and Operational Goals
(2) Early Systematic Approaches
Strategic and Operational Goals
(3) Aligned Approaches
Strategic and Operational Goals
(4) Integrated Approaches
Strategic and Operational Goals

Operations are characterized by activities rather than by processes, and they are largely responsive to immediate needs or problems. Goals are poorly defined.

The organization is at the beginning stages of conducting operations by processes with repeatability, evaluation and improvements, and some early coordination among organizational units. Strategy and quantitative goals are being defined.

Operations are characterized by processes that are repeatable and regularly evaluated for improvement, with learnings shared and with coordination among organizational units. Processes address key strategies and goals of the organization.

Operations are characterized by processes that are repeatable and regularly evaluated for change and improvement in collaboration with other affected units. Efficiencies across units are sought and achieved through analysis, innovation, and the sharing of information and knowledge. Processes and measures track progress on key strategic and operational goals.

Contributing to crisis management in CDCR healthcare are its geographic scatter and quasi-autonomous institutions; its subordination to custody; its silo divisions into medical, mental health, and dental; its vulnerability to political machinations; and its chronically impoverished infrastructure and leadership, all rendering it unable to plan and follow through. The Receiver has begun to address these inherited dysfunctions and to serve a central coordination role among the involved Courts.

[6] High Reliability

The right people and systems must be in place to ensure that inmates get the right care in the right place at the right time. Change must be both top-down and bottom-up, with a focus on staff engagement and empowerment and a relentless emphasis on training and communication. The infrastructure must support innovation among front-line clinicians, must facilitate innovations from the "outside" world, and must be able to disseminate evidence-based practices. Responses to error and bad outcomes must move from finger-pointing to an honest, comprehensive critique that includes analysis of individual human factors as well as team factors, communication, and organizational effectiveness.

The interdependence of medical care and custody presents opportunities as well as challenges. Reliability—ensuring that the right thing happens every time—is a goal of custody just as it is within medical care. Some organizations in the military, law enforcement, and emergency services have achieved remarkable improvements in reliability by developing a strong safety culture, utilizing personnel and equipment back-up systems, promoting inter- and intra-group communication, cross-training personnel, and focusing attention on errors and near-misses without wrongfully blaming or absolving individuals. The CDCR already partners with one such organization, the California Department of Forestry and Fire Protection, in its successful inmate firefighting program. Achieving reliable prison medical care in California will depend upon new levels of collaboration and respect between medical care and custody. Developing shared language and practices for reliability and safety will hasten this collaboration.

D. *The Practicalities of Prison Health Care Remediation*

Most of Initiatives can be divided into three general categories of remedial activity: (1) establishing the necessary infrastructure for constitutionally adequate prison medical care (*see e.g.*, the Contract and Invoice Processing Initiative, the Personnel Initiative, the Information Technology Initiative, etc.); (2) providing direct improvement to clinicians in the trenches (*see e.g.*, the six Clinical Initiatives and the Maxor Initiative); and (3) running the day-to-day CDCR medical services operations (*see e.g.*, the Out-of-State, Community Correctional Facilities, and Re-entry Oversight Initiative and the Class Action Coordination Initiative). A few, however, function to create change in more than one category.

To achieve long-term sustainable reform of the CDCR medical delivery system and thereafter return medical to the State, all three categories of remedial action are necessary. Far too often false visions of the Receivership lead to unreasonable expectations, and demands for remediation which are excessive and hence, unachievable. When evaluating the revised POA and the Receiver's 22 Initiatives, it may be helpful to consider the five common fallacies of prison remediation. And at all times, the final objective of the long-term, sustainable change sought by the Receivership must be kept in mind: return to the State a constitutional prison medical delivery system.

1. *"It's simple."* No, it's not. For just one example of the complexity of remedial plan development, review carefully the Information Technology Initiative.

[7] 2. *"We know what's wrong."* No, you don't. No one disputes the fact that the end result of the CDCR's medical delivery system is unconstitutional care. However, the underlying cause of this unconstitutional care has proven to be, almost always, far more serious, interconnected, and broken that previously assumed by the CDCR, the Court experts, and counsel. Take, for example, the CDCR's failure to deliver inadequate specialty care. This essential service requires the following: (1) a system that allows prisoner/patients the opportunity to be scheduled for timely sick call regardless of their classification; (2) adequate sick call screening by a competent nurse following appropriate policies and procedures; (3) the appropriate referral to a primary care provider (PCP) (mid-level or physician) through some form of adequate referral system; (4) access, in a timely manner, to a patient's medical record that is organized in a professional manner; (5) an adequate evaluation by a competent primary care provider; (6) an adequate, timely program to review specialty care referrals and to approve valid referrals to the necessary specialist; (7) a system to schedule and track either an in-prison or out-of-prison specialty referral; (8) an adequate contract with a competent

specialty provider, regardless of the geographical isolation of the prison; (9) a system to manage specialty provider contracts to ensure adequate statewide specialty coverage, the appropriate compensation to attract specialists, and (10) a system to pay the invoices of specialty providers in a timely manner; (11) a system to escort/transport the patient from his/her cell to either an in-prison specialty care area (space permitting) or to an out-of-prison specialty provider (perhaps 100 miles away); (12) an adequate number of trained correctional officers to effectuate timely medical transportation duties; (13) vehicles for medical transportation services and vehicles to provide the appropriate security escorts for high-security prisoner/patients; (14) a timely system to receive and evaluate the specialist's report; (15) a system to place that report, and thereafter maintain it in a designated section of the patient's medical record; (16) a system to schedule and track the follow-up care and/or tests ordered by the specialist; (17) a system and the competent clinical staffing to review the specialist's recommendation and thereafter effectuate a treatment plan. In some prisons every one of these requirements is inadequate, in other prisons some are adequate and some are not. Concerning certain requirements—for example scheduling and tracking systems, medical records, and correctional officer support staffing—deficiencies exist at every CDCR prison. At present there is not, for example, an adequate medical scheduling and tracking system within the CDCR. Therefore, to fix specialty care, the Receiver must fix a multitude of in-prison clinical problems and, at the same time, establish the necessary information technology, clinical support services, contracts, invoice payment, and transportation infrastructure to effectuate and manage this critical remedial program.

3. *"The Receiver can do whatever he wants."* No, he can't. The Court created the extraordinary remedy of a Receivership but, at the same time, carefully crafted the Order of February 14, 2006 to ensure compliance with appropriate principles of Federalism. Many of the steps that have proven necessary to bring medical services in California's prisons up to constitutional minima, such as salary increases for clinicians, realistic and effective peer review processes, effective contract procurement, cost effective pharmacy services, and timely, cost effective prison [8] medical bed construction, have required that the Receiver return to the Court to seek waivers of State law. These processes take time. While the Receiver has extraordinary powers, prison remedial work under the Receiver still requires diligence, cooperation, and sound communication from the State, the CDCR, and counsel.

4. *"Change will be much faster under the Receivership."* Sometime yes, sometimes no. The Receiver can—and he has—established remedial programs, hired clinical staff, implemented policies, and begun to create the infrastructure necessary for constitutional medical care much faster than the State ever could. Indeed, without the Receiver, many recent and successful programs would neither have been implemented, nor would they be functioning effectively. However, some of the systemic causes of the un-

constitutional delivery of medical care, for example, the State's trained incompetence and the CDCR's destructive culture, have proven far less tractable to timely change—no matter how many orders are issued. Changing mindsets and modifying deeply entrenched bureaucratic incompetence and the ingrained CDCR disdain for prisoners will occur more slowly—through the influence caring clinicians, a sound infrastructure, and proven remedial plan success.

And operating day-to-day medical requires far more than simply "brainstorming". It requires directing clinical and support personnel. Straightening out dysfunctional .business and financial systems It also calls for responding to emergencies, a daily occurrence in CDCR. As well it requires responding to new political, administrative and legislative initiatives promulgated by State government.

5. *"All the Receiver has to do is to fix things."* Not true. Given the absolute disarray of the CDCR, the Receiver and his staff decided, in December 2006, that they also had to manage the day-to-day medical care operation within all of California's prisons, as well as the CDCR medical services central office. And operating day-to-day medical care requires far more than simply providing oversight to clinical personnel. It also requires overhauling dysfunctional business and financial systems. It requires responding to emergencies, a daily occurrence in CDCR. As well, it requires responding to new political, administrative and legislative initiatives promulgated by State government. In many ways, the status of the Receivership is akin to a sailor in a rowboat

during a typhoon, steering the rudder with one arm while bailing-out the boat with the other. Responsible for day-to-day medical operations, the Receiver must also carefully coordinate *Plata* remedial Initiatives with *Armstrong*, *Coleman*, and *Perez*, and at the same time deal with custody decisions that have a direct, often negative impact on prisoner medical care, such as out of state transfers, conversion of prison missions, and expansion of community programs, etc. The Receiver is not just fixing the system, he's literally running it while remedies are developed and implemented.

E. *A Word on Metrics*

As can be seen by the detail provided in the Initiative narratives, the Receiver has taken very seriously the Court's instructions concerning timelines and metrics. The *American* [9] *Heritage Dictionary* defines *metric* as "a standard of measurement." *Stedman's Medical Dictionary* defines metrics as "the application of statistics and mathematical analysis to a field of study—biometrics." *Black's Law Dictionary* does not define *metrics*. The Baldrige National Quality Program, on the other hand, defines "measures and indicators" as: "numerical information that quantifies input, output, and performance dimensions of process, programs, projects, services, and the overall organization (outcomes)." There is may be useful to clarify that in the context of the remedial process, the Receiver is measuring his remedial progress by using a number of different, although interrelated, metrics—including the following:

1. *Court-Mandated Metrics*: The Stipulated Injunctions in this case call for the development and implementation of policies and pro-

cedures concerning the delivery of prison medical care. For certain services, standards are required (for example, patients who need to access sick call should do so under time standards which vary according to acuity, and patients with chronic diseases should be seen by a PCP within established time periods, etc.). The Court-mandated metrics, many of which can be characterized as "access-to-care" metrics, will be measured by the Inspector General's prison program that will objectively measure the basics of *Plata* remedial plan compliance at no less than six pilot prisons (as proposed by the Receiver in May 2007).

2. *Time-Based Metrics Concerning the Implementation of Receiver Remedial Programs*: The Receiver has established time frames for each Initiative in six month, 12 month, 24 month, and 36 month intervals. A chart is attached which illustrate these metrics. Progress will be reported in the Quarterly Reports. Successes and failures to meet these objectives will be public information.

The Receiver, however, does not believe that it is appropriate to limit his establishment of metrics to those mandated by the Court. In fact, the Receiver has concluded that the limited "access-to-care" metrics of *Plata*, while useful to measure certain end results, were not, in themselves, adequate to determine if an infrastructure existed to support the access-to-care mandates. Therefore, in order to effectuate timely and sustainable change, the Receiver has also begun to implement two additional forms of metrics: administrative performance measures and clinical quality measures.

3. *Infrastructure/Administrative Performance Metrics*: Now that Receivership has initiated enhancements to the administrative infrastructure, he has also established measurements of the "bottom line" success of the infrastructure. For example, the metric to measure the success of clinical hiring (a process which includes establishing appropriate salaries, recruitment, and hiring itself) is established as a less than 10 percent vacancy rate of full time permanent State employees for physicians, mid-level providers, registered nurses, and licensed vocational nurses by December 2008. As set forth in the Initiatives, certain infrastructure functions are developed to the point where specific performance measures are appropriate now, while others, still developing, will implement performance measures in the future. Without question, however, bottom-line performance measures for infrastructure services will be a Receivership requirement.

[10] 4 *Clinical Quality Measures*: Perhaps the most important set of metrics, however, are those which will evaluate the quality of care delivered to prisoner/patients. This form of metric, not contemplated by the original *Plata* stipulations—but absolutely necessary for remedial plan success—will include information concerning health care outcomes; epidemiological data and population-based health outcomes; practice guidelines; administrative, workforce, cost, and financial per-

formance; benchmark comparisons; patient satisfaction; and compliance with Court orders.

To summarize, the Receivership will, in the 36 months ahead, implement and establish programs to comply with at least four distinct sets of metrics. During this period it is important that all stakeholders in the Plata remedial process understand the importance of *both* Court-mandated metrics and those additional performance and quality-based metrics without which long-term sustainable reform will not be possible.

Executive Summary of November 15, 2007 Initiatives

[1] INTRODUCTION

The November 2007 iteration of the Receiver's Plan of Action focuses on 22 Initiatives, each of wide-ranging importance and impact. Each Initiative is described by a narrative that includes background information, current status, objectives for the next six months, 12 months, 24 months and 36 months, relevant metrics, and potential barriers. The Initiatives are summarized below:

INITIATIVES

1. *Clinical Initiatives*

    a. *Medical Staff Professional Development* (POA Objective A.7)

Implement a program to attract and retain excellent physicians, nurse practitioners, and physician assistants through the following strategies: assisting providers in maintaining and improving their clinical acumen with educational programs and support; offering targeted remedial opportunities for providers with remedial deficiencies; developing medical staff and interdisciplinary committees consistent with professional standards; developing a frontline cadre of managerial staff with quality improvement and leadership competencies; and establishing expectations and processes in the prisons in support of professionalism and ethical behavior.

    b. *Nursing Executive Leadership Initiative* (POA Objective A.7)

Establish a cadre of nurse executives through the Receiver's Career Executive Assignment program.

Implement a three-prong support program: (1) effective recruitment and the establishment of relevant minimum job requirements; (2) defining roles and responsibilities and providing necessary assistance to meet those objectives; and (3) developing effective reporting mechanisms.

c. *Healthcare Orientation, Nursing Preceptor Program, and Provider Proctoring Program* (POA Objective A.8.1 and A.8.5)

Implement a clinically-based nurse (licensed vocational nurse and registered nurse); physician, and mid-level provider orientation program at five prison pilot sites consisting of formal orientation programs, nurse preceptor program, and provider proctoring program.

d. *Nursing Medication Delivery Process Redesign* (POA Objective B.8)

Redesign the prison medical delivery process to ensure patient-centered, common formulary, standardized, quality medication delivery in conjunction with the roll-out of the Maxor GuardianRx pharmacy system.

[2] e. *Asthma Initiative* (POA Objective B.3.1)

Institute a pilot program to eliminate this common cause of preventable deaths within the CDCR, engaging six strategies of organizational change: (1) redesign of care practices based on best practices ; (2) use of information technology to support care givers ; (3) increasing clinical skills ; (4) developing team-based medical delivery systems ; (5) coordination of care; and (6) incorporation of performance and outcome measures for tracking improvement and accountability.

f. *Emergency Response Initiative* (POA Objective B.1.1)

Improve emergency medical care within prisons, improve patient clinical outcome, and thereby decrease unexpected death due to lack of EMS care by establishing pilot projects to implement the Receiver,s approved statewide Emergency Medical Response System policy. This process will include training of staff, developing mechanisms to improve local preparedness, conducting assessments of emergency equipment, space, vehicles, staffing matrixes, developing accurate data concerning emergency responses, and the creation of prison-specific Emergency Response Review Committees.

2. *Clinical Operations Initiatives*

a. *Clinical Quality Measurement and Evaluation Initiative* (POA Objective C.2, C.6 and C.8)

Establish a new administrative unit of CDCR employees (who report to the Receiver) to develop and implement necessary clinical measurement and evaluation standards (clinical metrics). In addition, the unit will manage the Receiver's quality-based programs including CDCR healthcare credentialing and privileging unit, headquarters-based peer review (Professional Practice Executive Committee), death reviews, and the new Medical Oversight Unit (a collaborative pilot project to improve clinical investigations involving the Office of the Receiver, CDCR Internal Affairs, CDCR Legal Affairs, and the Office of the Inspector General).

b. *Clinical Support Services Initiative* (POA Objective B.12)

Establish a new administrative unit of CDCR employees (who report to the Receiver) to manage the Receiver's enhanced programs for radiology, medical records, laboratory services, pharmacy, and telemedicine.

3. *Construction Initiatives*

a. *San Quentin Construction Initiative* (POA Objective F.2)

Continue a number of essential construction projects currently underway at San Quentin State Prison, including establishing new, improved sick call units in facility rotundas, building a [3] temporary medical building to provide needed clinical offices and space, constructing a medical supply warehouse, and constructing the San Quentin Central Health Services Facility, a state of the art correctional health care center which serves the needs of four Federal Court class actions: *Armstrong*, *Coleman*, *Plata*, and *Perez*.

b. *5,000 Prison Medical Bed Construction Initiative* (POA Objective F.3)

Coordinate and lead a program to construct up to 5000 medical beds and up to 5000 mental health beds, utilizing carefully prepared patient demographic reports to establish the number and acuity levels of the beds needed. Working with a previously selected construction management firm, implement seven preconstruction strategies over the course of the next six months with the objective of commencing construction between April—June 2008: (1) site assessment and selection; (2) CEQA review and evaluation; (3) infrastructure review and development of remediation plans; (4) facility planning (a process which includes representatives from the other class actions); (5) program delivery; (6) obtaining funding; (7) development of an overall Project Management Plan.

c. *Facility Improvement Construction Initiative* (POA Objective F.1)

Provide desperately needed clinical space and clinical support space in existing California prisons, utilizing a carefully developed, coordinated (with other Federal Court class actions and AB 900 planning) formal space evaluation process. Facility improvement planning has been completed at Avenal State Prison and the Correctional Treatment Facility, and has begun at the California Rehabilitation Center. The evaluation/formal planning process will be completed at 15 prisons within 12 months, with an additional 13 prisons completed by December 2009. Construction will proceed according to an aggressive, formalized schedule subject to availability of funding.

4. *Custody Access Initiative* (POA Goal E)

Perform carefully designed formal health delivery oriented custody operational reviews at every California prison in order to establish the necessary correctional officer posts to provide adequate, timely prisoner/patient access to health care services. An initial review will be followed-up by a second evaluation relating in part to the Facility Improvement Construction Initiative, and eventually, pursuant to a time-phased schedule, the establishment of formal (and cost effective) health care Custody Access Teams at each prison.

5. *Administrative Initiatives*

a. *Out-of-State, Community Correctional Facilities, and Re-entry Facility Oversight Initiative*

Commence operation of a new administrative unit which will: (1) establish clinical standards and health care staffing standards for Out-of-State, Community Correctional Facilities, and Re-entry Facilities, manage necessary Out-of-State, Community Correctional Facilities, and Re-entry Facilities contract modifications to ensure compliance with the remedial orders of the [4] Federal Court health care class actions, establish and implement an Out-of-State, Community Correctional Facilities, and Re-entry Facilities inspection protocol and schedule; and (2) serve as an interface between the Office of the Receiver and the Inspector Generals' pilot *Plata* compliance prison inspection process, participating in the inspections as necessary.

b. *Contract and Invoice Processing Initiative* (POA Objective A.4 and A.6)

Roll out to 33 prisons the new Health Care Document Management System (HCDMS), providing phase one of an Information Technology solution to CDCR contract unit's chronic problems with timely procurement and invoice processing. Centralize, as part of the roll out process, invoice review and payment functions. Process, under HCDMS, 90% of bid contracts within 60 days. Process, under HCDMS, 98% of contract invoices within 30 days. Working with a retained consultant, enter into timely, cost effective agreements with hospitals who serve prisoner/patients, and provide training for contract personnel concerning hospital negotiations and contract processes. Secure a consultant review concerning the entire CDCR health care contracting process with the objective of developing a plan for a Statewide network of hospitals and specialty providers to serve all CDCR prisoner/patients.

c. *Fiscal Services Initiative* (POA Objective A.2.4 and A.2.5)

Develop and implement a Fiscal Management Section within the Plata Support Division to establish the necessary fiscal support infrastructure for the Receiver's medical care operation, both in the Central Office and in the prisons. Prepare budget related documents for the Department of Finance as necessary. Provide timely and accurate budget information to the Receiver and his staff to effectuate a more efficient and cost effective health care operation at all levels. Monitor and participate in the CDCR's implementation of the Business Information System (BIS).

d. *Personnel Services Initiative* (POA Objectives A.7, A.8, and A.8.5.3)

Create the necessary infrastructure, at Central Office and in the field, recruitment programs and expedited hiring practices to reduce the full-time, permanent, State employed clinical vacancies (Physicians, Mid-Level Provider, Registered Nurse, and Licensed Vocational Nurses) to less than 10% by December 2008. Also establish, within 6 months, the following programs: a program for recruiting and hiring of Receiver Career Executive Assignment personnel for key CDCR clinical leadership positions (and executive health care management positions at three pilot institutions); an appropriate credentialing tracking system; and a functioning employee discipline unit to provide manager education and "hands on" assistance concerning employee discipline matters.

e. *Health Care Appeals, Correspondence Control, and Habeas Corpus Petitions Initiative* (POA Objective C.3)

Centralize the controls and management over all CDCR health care prisoner/patient Appeals, Correspondence Control, and Habeas Corpus Petition responses, and include in this process a pilot project to utilize clinical personnel to evaluate/screen certain cases. Implement [5] timely changes to the existing appeal system as it pertains to the initial receipt of appeals and "third level" appeal responses. Develop and provide recommendations to the Receiver a long term, sustainable and improved system for a new appeal process within 6 months.

6. *Information Technology Initiative* (POA Goal D)

Establish a wide area network connection at all 33 CDCR prisons within six months. Install a local area wireless network within a selected number of pilot prisons within six months. Establish a data center, and thereafter a data repository, and the necessary clinical portal (a web based browser that will allow access by staff into the repository), all within 12 months. Utilize the recently established Health Care Information Technology Executive Committee (HITECH) to formulate recommendations concerning software and those applications which should assume priority for implementation.

7. *Maxor Pharmacy Services Initiative* (POA Goal B.8)

Continue the Maxor roadmap for change in the CDCR's pharmacy program, including the time-phased roll-out of the GuardianRx pharmacy system, developing and establishing revised policies, procedures and practices within the prison pharmacies, planning for and establishing a central fill pharmacy building, and continuing the implementation of existing Receivership/Maxor programs to manage CDCR pharmacy purchasing contracts.

8. *Pilot Project Initiatives*

   a. *San Quentin Project Initiative* (POA Objective B.2)

Continue the San Quentin Pilot, including the development of improved nursing and administrative initiatives, the implementation of the enhanced, coordinated Reception Center process, and the construction of new clinical facilities at San Quentin as described above.

   b. *Specialty Services Pilot at California State Prison—Los Angeles County and California Correctional Institution* (POA B.2 and B.3)

Continue the development of pilot programs at two prisons to provide enhanced prisoner/patient specialty services, focusing on improved contract procurement with specialty providers, more timely specialty provider invoice processing, improved specialty services scheduling and tracking, establishing additional controls and better responses to patient "refusals," and providing additional clinicians, correctional officers, and transport/escort vehicles to effectuate more timely out-of-prison specialty care delivery.

9. *Class Action Coordination Initiative*

Continue monthly meetings with the Court representatives (and quarterly meetings with the District Court Judges) overseeing the four Federal Court class action cases currently pending: *Armstrong* (Americans with Disabilities Act); *Coleman* (mental health); *Plata* (medical), and Perez (dental) to ensure coordinated and cost effective systemic remedial action, and to establish [6] various "coordination agreements" whereby the District Court Judges agree that the Receiver in *Plata* will take a leadership role when developing and implementing selected remedial programs which impact on all four class actions.

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[1] IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF CALIFORNIA AND
THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

NO. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NO. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER STAYING PROCEEDINGS

The Honorable Thelton E. Henderson held a status conference in this case on December 13, 2007, and has consulted with all judges on this court. After careful consideration of the parties' arguments and the unique factual circumstances of this case, including the very tight timelines originally imposed by this court on the parties, the court finds good cause to order as follows:

1. All pretrial and trial dates are VACATED pending further order of the court.
2. Defendants' December 7, 2007 motion for reconsideration is DENIED, except as provided in paragraph 3 *infra*.

[2] 3. All discovery is stayed, with the following exceptions:

   a. Any depositions that have already been noticed and scheduled between now and the previously scheduled discovery cut-off of December 20, 2007 may proceed, and parties shall respond to any outstanding written discovery that has already been propounded.
   b. Defendants' request for additional time to review and revise their privilege logs is GRANTED IN PART. The matter is referred back to the magistrate judge for further proceedings in connection with Defendants' review and revisions, which shall be completed no later than forty-five calendar days from the date of this order.

4. The question of the dates for filing expert reports and the issues relating to witness depositions raised at the December 13, 2007 status conference remain under submission.
5. The Court will set a status conference by subsequent order.

IT IS SO ORDERED.

Dated: 12/14/07

/s/ STEPHEN REINHARDT
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

Dated: 12/14/07

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: 12/14/07

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

No. CIV S-90-0520 LKK JFM P (E.D.Cal.)

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH (N.D.Cal.)

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 05-05241 JSW (N.D.Cal.)

CARLOS PEREZ, *et al.*,
Plaintiffs,
vs.
JAMES TILTON, *et al.*,
Defendants.

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[2] No. C 94-2307 CW (N.D.Cal.)

JOHN ARMSTRONG, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER

The Receiver in *Plata*, the Special Master in *Coleman*, and the Court Representatives in *Perez* and *Armstrong* have presented to the judges in the above-captioned cases for review and approval an agreement that they have reached during the coordination meetings that they have held to date. By order filed November 13, 2007, the parties in the above-captioned cases were granted until November 26, 2007, to show cause why the attached agreement should not be adopted as an order of the court. On November 26, 2007, all parties filed responses to the order to show cause. Thereafter, by order filed November 30, 2007, the Plata Receiver, at his request, was granted fifteen days to file a response to the responses filed b: the parties. The Receiver's response was filed on December 17, 2007.

The undersigned have reviewed, individually and jointly, the responses of the parties and of the Receiver. Good cause appearing, the construction agreement will be approved subject to the following conditions. The Receiver shall file quarterly reports in each of the above-captioned cases concerning developments pertaining to the matters that are the subject of the construction agreement. In addition, the Receiver has indicated that he will be prepared to meet with the parties within the next sixty days concerning the status of the construction of 5,001 mental health beds and 5,000 medical beds that is the subject of paragraph 3 of the construction agreement. That will be the order of the undersigned.

In accordance with the above, IT IS HEREBY ORDERED that:

1. The construction agreement appended to this order is approved;

[3] 2. The *Plata* Receiver shall file quarterly reports in each of the above-captioned cases concerning developments pertaining to matters that are the subject of the construction agreement;

3. The first such quarterly report shall be filed on or before March 15, 2008; and

4. Within sixty days from the date of this order the *Plata* Receiver shall meet with the parties to all of the above-captioned actions, the *Coleman* Special Master, and the *Perez* and *Armstrong* court representatives concerning the status of the construction of 5,000 mental health beds and 5,000 medical beds that is the subject of paragraph 3 of the construction agreement.

DATED: 02/26/08

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

DATED: 02/26/08

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

DATED: 02/26/08

/s/ JEFFREY S. WHITE
JEFFREY S. WHITE
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

DATED: 02/26/08

/s/ CLAUDIA WILKEN
CLAUDIA WILKEN
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[4] CONSTRUCTION

The Receiver in *Plata* has begun to implement three separate but related construction projects:

A. The construction of a medical center at San Quentin State Prison;

B. The addition of needed temporary and permanent clinical, office, supply, and record space at existing California Department of Corrections and Rehabilitation (CDCR) adult prisons; and

C. The construction of approximately 5,000 additional CDCR medical beds and approximately 5,000 CDCR mental heath beds.[1]

The Office of the Receiver will assume leadership responsibility for each of the above referenced projects.

1. *San Quentin Medical Center.* The *Plata* receivership is the project lead for the San Quentin construction. The Medical Center, which has already been designed and for which construction has commenced, will provide additional reception, clinical, treatment, and office space for CDCR medical, mental health, and dental personnel. Medical Center facilities will be ADA compliant. Court representatives from *Perez* and *Coleman* as well as CDCR mental health and dental officials have been active participants in the design stage for this construction. The State has determined that funding for the San

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[1] The actual number of medical and mental health beds to be constructed by the Receiver will depend upon site selection, contingency issues, determinations concerning what year to build out to, as well as possible coordination of construction with CDCR's AB 900 building projects.

Quentin Medical Center will be provided through Assembly Bill (AB) 900 funds.

2. *Additional temporary and permanent clinical, office, supply, and record space at CDCR prisons.* The *Plata* receivership is the project lead for the additional medical construction projects at existing CDCR institutions. The Receiver is in the process of implementing his initial prison upgrade project at Avenal State Prison. Court representatives from *Coleman* and *Perez* have participated in this initial effort. The upgrades anticipated will be primarily medical; however the upgrades will be ADA compliant and will consider, when possible, some of the additional space needs of the CDCR mental health and dental programs. In this regard, the Court representatives in *Armstrong*, *Coleman*, and *Perez* agree to work with the Receiver by exploring with CDCR and their respective courts ways to effectuate the funding necessary for their specific programs in a timely and effective manner. This project will *not* involve the construction of the additional dental facilities necessary to effectuate the *Perez* roll-outs.

3. *The construction of approximately 5,000 additional CDCR medical beds and approximately 5,000 CDCR mental heath beds.* The *Plata* receivership is the project lead for the 5,000/10,000 bed construction project. URS Corporation, Bovis Lend Lease, Brookwood Program Management, Lee Burkhard Liu, and Robert Glass & Associates will serve as the Receiver's Project Coordinator for 5,000/10,000 bed construction. The initial planning for design, site selection, and patient demographics will commence during August 2007.

Based on an initial review of the patient demographics by the Abt study, the Receiver anticipates that the majority of medical beds constructed will not be licensed. Given the significant need to [5] coordinate the long-term treatment and care of mentally ill patients who also have serious medical problems, there exist both strong patient care and fiscal incentives to plan, design, and construct health care facilities that will effectuate coordinated medical and mental health treatment. Therefore, participation by *Coleman* representatives in this construction program is imperative. Likewise, the special needs of disabled and elderly prisoner/patients, who represent a significant number of patients who require improved housing, warrant participation by an expert in accessibility for persons with disabilities. The Court expert in *Armstrong* and the Receiver in *Plata* mutually selected such an expert who will be added to the program and who will communicate with both the *Armstrong* court expert and the Receiver about his recommendations. The new facilities will be designed and built to be in full compliance with applicable ADA requirements for both staff and inmates, including applicable accessibility provisions of the ADA Accessibility Guidelines, the Uniform Federal Accessibility Standards, and California Code of Regulations, Title 24, Part 2, California Building Code (CBC). The Receiver also intends to construct adequate dental clinics and other necessary dental program space in order to provide *Perez* standards of care for the prisoner/patients housed in the 5,000/10,000 bed facilities. Therefore, participation by a *Perez* representative will be necessary to coordinate dental construction design and planning. In this regard, the Court representatives in *Armstrong*, *Coleman*, and *Perez* agree to work with the Receiver by exploring with CDCR and their respective courts ways to effectuate the funding necessary for their specific programs in a timely and effective manner.

This project will *not* involve the construction of the additional dental facilities necessary to effectuate the *Perez* roll-outs.

The State has determined that funding for an 8,000-beds construction project will be provided through AB 900 funds. The *Coleman* Special Master and the *Plata* Receiver have indicated that up to 10,000 beds may be necessary. Whether the projected funding is adequate for the necessary construction will be determined by the Receiver after site selection issues, coordination issues, and design issues are resolved.

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF CALIFORNIA AND
THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

NO. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NO. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER SETTING STATUS CONFERENCE AND TRIAL DATE AND ORDER STAYING DISCOVERY

As discussed during the May 30, 2008 status conference, the Court finds good cause to order the following:

1. Discovery is hereby STAYED until June 30, 2008, except for the following:

   a. All pending motions before the magistrate judge;

   [2] b. The pending motion for reconsideration before this Court on the attorney-client privilege; and

   c. The motion for reconsideration regarding the deliberative process privilege that Defendants announced an intent to file during the May 30 status conference.

2. Absent any settlement, trial in this matter shall begin on November 17, 2008. Unless otherwise ordered, each trial day shall run from 9:15 AM until 4:00 PM. The Court may also decide to hold trials on Tuesdays through Fridays only, in which case the start of trial may be delayed until November 18, 2008. Trial shall be held in the United States District Court for the Northern District of California, located at 450 Golden Gate Avenue, San Francisco, California.[1]

3. The parties and intervenors shall meet and confer regarding: (1) proposed new discovery deadlines given the thirty-day stay ordered above; (2) proposed pretrial dates to accompany the November trial date; and (3) the estimated length of trial. The parties and intervenors shall set forth their views on these issues, and any other relevant issues, in a joint status conference statement to be filed on or before June 9, 2008. The Court will carefully consider the parties' and intervenors' proposals but retains discretion to set its own pretrial dates and deadlines. The parties

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[1] The Court will identify at a later time the particular courtroom in which trial will occur.

and intervenors are advised that if they propose a dispositive motion schedule, they shall explain why such a schedule is necessary given the extensive factual disputes that exist in this case.

[3] 4. The parties and intervenors shall appear for a status conference before this Court on Friday, June 27, 2008, at 10:30 AM. The status conference shall be held in the Ceremonial Courtroom of the United States District Court for the Northern District of California, located on the 19th Floor at 450 Golden Gate Avenue, San Francisco, California.

IT IS SO ORDERED.

Dated: 05/30/08

On behalf of the Court:[2]

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

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[2] Under 28 U.S.C. § 2284(b)(3), a single judge on a three-judge court "may conduct all proceedings except the trial, and enter all orders permitted by the rules of civil procedure except as provided in this subsection. He may grant a temporary restraining order on a specific finding, based on evidence submitted, that specified irreparable damage will result if the order is not granted, which order, unless previously revoked by the district judge, shall remain in force only until the hearing and determination by the district court of three judges of an application for a preliminary injunction. A single judge shall not appoint a master, or order a reference, or hear and determine any application for a preliminary or permanent injunction or motion to vacate such an injunction, or enter judgment on the merits. Any action of a single judge may be reviewed by the full court at any time before final judgment."

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER RE: ROLE OF RECEIVER AND SPECIAL MASTER REGARDING PRISON POPULATION ADVISORY GROUP

At the status conference conducted in the above-captioned proceedings on May 30, 2008, there was a discussion concerning the membership of an advisory group that will perform a detailed analysis of the operational capacity of each California prison facility in an effort to arrive at an agreement on a prison population cap. *See also* Confidential Status Report, filed June 2, 2008, at 8-9.

A question arose concerning what role, if any, the *Plata* Receiver and the *Coleman* Special Master might have in connection with that advisory group. As the Court noted in its November 29, 2007 order, both the *Plata* Receiver and the *Coleman* Special Master have assumed duties and obligations of a judicial officer and are acting as surrogates of the *Plata* [2] and Coleman courts, respectively. *See* Nov. 29, 2008 Order at 2. For that reason, it would not be appropriate for either the *Plata* Receiver or the *Coleman* Special Master, or any of their staff members, to serve on the advisory group. By this order, both the Receiver and the Special Master will be authorized to provide, in their discretion, on an informal basis such information as the advisory group may seek from them that may be helpful to the goals of said group. Nothing in this order shall be construed to permit any member of the advisory group to request preparation of written reports by the Receiver or the Special Master or any of their staff members, or to permit any party to these proceedings to request formal testimony from the Receiver or the Special Master or any of their staff members at any stage of these proceedings.

IT IS SO ORDERED.

Dated: 06/05/08

/s/ STEPHEN REINHARDT
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

Dated: 06/05/08

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: 06/05/08

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[1] UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

[Filed 06/06/2008]

Case No. C01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NOTICE OF FILING OF THE RECEIVER'S TURNAROUND PLAN OF ACTION

PLEASE TAKE NOTICE that the Receiver in *Plata v. Schwarzenegger*, Case No. C01-1351 TEH has filed his Turnaround Plan of Action, attached hereto.

Dated: June 6, 2008

FUTTERMAN & DUPREE LLP

By: /s/ Martin H. Dodd
Martin H. Dodd
Attorneys for Receiver J. Clark Kelso

[2] CERTIFICATE OF SERVICE

The undersigned hereby certifies as follows:

I am an employee of the law firm of Futterman & Dupree LLP, 160 Sansome Street, 17th Floor, San Francisco, CA 94104. I am over the age of 18 and not a party to the within action.

I am readily familiar with the business practice of Futterman & Dupree, LLP for the collection and processing of correspondence.

On June 6, 2008 I served a copy of the following document(s):

NOTICE OF FILING OF THE RECEIVER'S TURNAROUND PLAN OF ACTION

by placing true copies thereof enclosed in sealed envelopes, for collection and service pursuant to the ordinary business practice of this office in the manner and/or manners described below to each of the parties herein and addressed as follows:

___ BY HAND DELIVERY: I caused such envelope(s) to be served by hand to the address(es) designated below.

_X_ BY MAIL: I caused such envelope(s) to be deposited in the mail at my business address, addressed to the addressee(s) designated. I am readily familiar with Futterman & Dupree's practice for collection and processing of correspondence and pleadings for mailing. It is deposited with the United States Postal Service on that same day in the ordinary course of business.

___ BY OVERNIGHT COURIER SERVICE: I caused such envelope(s) to be delivered via overnight courier service to the addressee(s) designated.

___ BY FACSIMILE: I caused said document(s) to be transmitted to the telephone number(s) of the addressee(s) designated.

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Oakland, CA 94612-0550

___ [State] I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

X [Federal] I declare that I am employed in the offices of a member of the State Bar of this Court at whose direction the service was made. I declare under penalty of perjury, under the laws of the united State of America, that the above is true and correct.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on June 6, 2008, at San Francisco, California.

/s/ Lori Dotson
Lori Dotson

[1] CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

J. Clark Kelso
Receiver

June 6, 2008

Honorable Thelton E. Henderson
Chambers of Judge Henderson, U.S.D.C.
Northern California District
450 Golden Gate Avenue, 19th Floor
San Francisco, CA 94102

Dear Judge Henderson:

I am pleased to submit to the Court for its approval the Plan of Action required by the Court's Order Appointing Receiver and Order Appointing New Receiver

Attached is the Turnaround Plan of Action for your review. If you have any questions, you may call me directly at (916) 323-1264.

Sincerely

/s/ J. Clark Kelso
J. Clark Kelso

Attachment

Achieving a
Constitutional Level of Medical Care
in California's Prisons

The Federal Receiver's
Turnaround Plan of Action

June 6, 2008

[ii] CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

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June 6, 2008

The Honorable Thelton E. Henderson
United States District Court
Northern District of California
450 Golden Gate Avenue
San Francisco, CA 94102

Dear Judge Henderson:

The February 14, 2006 Order Appointing Receiver ("Order") requires the Receiver to "develop a detailed Plan of Action designed to effectuate the restructuring and development of a constitutionally adequate medical health care delivery system" (Order at 2:19-22), The Court's January 23, 2008, Order Appointing New Receiver further directed that I work with the Pro

Bono Special Assistant to the Court and a professional planner to "rework the. . . Plan of Action so that it is a more useful *leadership document*" (page 5, emphasis added).

I am pleased to submit for your consideration my Turnaround Plan of Action for bringing prison medical care services within California's Department of Corrections and Rehabilitation ("CDCR") up to federal constitutional standards. Because this is a turnaround plan designed to correct constitutional deficiencies in California's prison health care system, the plan does not contain action items for all components of the prison health care system. For example, the plan does *not* contain goals focused on treatment of infectious disease, alcohol and drug programs, palliative care, or public health. The Receivership is responsible for maintaining and developing all of these components, and the absence of these components from this plan is not intended to suggest a lack of attention on these elements of a comprehensive health care system. However, in terms of selecting priorities for initial investment of resources, these components are not as critically in need of improvement. Moreover, the improvements provided in the plan will in large part address many needs in these areas.

The Court's opinions in *Plata v. Schwarzenegger* and *Coleman v. Schwarzenegger*, and the orders in Perez v. Tilton and Armstrong v. Schwarzenegger, document and reflect pervasive, fundamental organizational weaknesses and failures within CDCR that undermine its ability to [iii] provide constitutionally adequate health care services. Having been given control over CDCR's medical program, the Receiver's job is to establish constitutionally adequate prison medical care as quickly as practicable and in a way which will be sustainable after the Receiver winds down operations and the responsibility for prison medical care reverts to the State. The Receiver is also required to coordinate planning and activities with federal judicial oversight of CDCR's mental health, access to Americans with Disabilities Act services, and dental programs.

There is no great mystery about what needs to be done. Constitutionally adequate health care occurs when patient-inmates are given

- timely access to competent medical and clinical personnel who provide effective care informed by accurate patient records and supported by appropriate housing, medical facilities, equipment and processes; and
- timely access to prescribed medications, treatment modalities, specialists and appropriate levels of care.

The elements listed above have not routinely existed within CDCR's medical delivery system. Access has not been timely. The number of medical personnel has been inadequate, and competence has not been assured. Accurate and complete patient records are often not available when needed. Adequate housing for the disabled and aged does not exist. The medical facilities, when they exist at all, are in an abysmal state of disrepair. Basic medical equipment is often not available. Medications and other treatment options are too often not available when needed—to be meaningful, access must be timely. This strategic plan establishes a three-to five-year framework for addressing all of these problems.

Absent these foundational elements, health care within CDCR consists of chaotic, episodic and often untimely encounters between patients and clinicians who, given the lack of reliable patient information and support systems, are placed in a responsive position with no incentives or feedback loops to encourage good medical practices. We need to transform the system to one in which encounters are:

- proactive,
- planned,
- informed,
- patient-centered, and
- professional.

Although it will take years to establish all of the necessary systems throughout the CDCR, we cannot wait years to take some immediate steps to stop the avoidable mortality and morbidity that exists within CDCR's health care system. Accordingly, in addition to building a long-term foundation for health care services, the Receiver must implement some programs immediately to improve care even before the proper foundation has been put in place. Successfully implementing these short-term programs will be challenging precisely because an adequate health care infrastructure—the foundation for quality health care—does not presently exist. [iv] However, even if some of the early actions are not as comprehensively planned or executed as would be desirable if we had the luxury of more time, these early steps will undoubtedly improve CDCR's health care system.

We have adopted six goals to focus our efforts. These goals, and their associated objectives and action items, summarize the steps necessary for CDCR's health care program to rise to constitutionally acceptable and sustainable levels. The goals are as follows:

1. Ensure Timely Access to Health Care Services
2. Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services
3. Recruit, Train and Retain a Professional Quality Medical Workforce
4. Implement a Quality Assurance and Continuous Improvement Program
5. Establish Medical Support Infrastructure
6. Provide for Necessary Clinical, Administrative and Housing Facilities

There has already been significant progress on some of these goals (comprehensive status reports appear in the quarterly reports which the Receiver files with the Court, reports that are on the Receiver's website at www.cprinc.org). For example, the recruitment of registered nurses has dramatically improved as a result of increasing compensation to market levels and vastly improved recruitment practices. Similar success is just now being seen in the recruitment of physicians. Substantial work has been completed at several prisons to improve conditions. Overall, however, we are at early stages in fully implementing our goals.

The total costs for implementing this plan are substantial (see Appendix A). Bringing prison medical care up to constitutional standards will require a significant investment of resources, both one-time capital expenses and an increase in ongoing operational expenses. This is not a good time to be putting additional demands on the state's budget. But there simply is no choice. The State of California has a constitutional obligation to improve its prison medical care system, and I am convinced the only way to satisfy that obligation is by making substantial investments today that will make up for 30 years of systematic under-investment in prison health care.

The Court's Order calls for periodic reports to the Court concerning our remedial progress (Order at 3:15-22). In addition to our Quarterly Reports, to keep the Court and public informed of our progress, and to hold ourselves accountable for our progress, we will add a "Progress Report" to the CPR website. The "Progress Report" will show how far along we are with each of our goals and objectives (a timeline and list of proposed metrics appears in Appendix A). It will be updated monthly.

[v] We are setting an aggressive time table for achieving our goals. The cooperation and support of the Governor and Legislature, as well as of a multitude of state and local agencies, will be required over the next several years. The Governor has personally committed to me his full support, and I am confident that I can work with legislative leaders to support our efforts.

I look forward to working with you, Judge Reinhardt, Judge Karlton, Judge White, and Judge Wilken as we endeavor to resolve California's prison health care crisis.

Sincerely,

/s/ J. Clark Kelso
J. Clark Kelso

Cc: The Honorable Stephen Reinhardt
The Honorable Lawrence K. Karlton
The Honorable Jeffrey S. White
The Honorable Claudia Wilken

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Goal 2. Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services

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Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

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Goal 6. Provide for Necessary Clinical, Administrative and Housing Facilities

- 6.1. Upgrade Administrative and Clinical Facilities
- 6.2. Expand Administrative, Clinical, and House Facilities
- 6.3. Finish Construction at San Quentin State Prison

[1]Vision

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

A receivership is an extraordinary judicial remedy employed by a federal court only as a last resort when all other attempts to secure compliance with court orders have proven futile. Because it is such an extraordinary remedy, and because federal courts are instructed to employ only as much equitable power as is necessary to cure a constitutional violation, it is incumbent upon the Receiver in this case to move with all possible speed to establish a constitutionally adequate prison medical care system. This is the Receiver's primary order of business.

For the Court's orders to be efficacious, the medical care system established by the Receiver must be sustainable long after federal court supervision has ceased. It is not enough to simply bring CDCR's health care system up to constitutional minimums. The system created must be one that the State itself will be able to maintain long into the future. As the Court stated in its October 3, 2005 Findings of Fact and Conclusions of Law Re Appointment of Receiver ("Findings"), the purpose of the Receivership is to bring the delivery of health care in California prisons up to constitutional standards and return a stabilized health care system back to the State (Findings at 2:8-13). Therefore, sustainability of the system under State management and control must be considered by the Receiver as we formulate our plans for building the foundation.

The vision statement strongly reflects the litigation context that led to the Receivership's creation and that influences the Receivership's planning, operations and termination. The vision statement speaks in terms of constitutional standards for health care, and it recognizes the boundaries of federal equitable relief. It is a vision grounded in a legal context.

[2] Mission

> Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.

As noted above, our vision statement is grounded in the legal context giving rise to the Receivership. Our day-to-day mission is of a very different quality. It is health care oriented and patient centric in its perspective. The mission explains and restates in more concrete terms, and from a health care perspective, what overall organizational and systemic changes the Receiver must achieve to fulfill the vision.

In many respects, the mission is a simple one: Reduce avoidable deaths and illness by giving patient-inmates:

- timely access to competent medical and clinical personnel who provide effective care informed by accurate patient records and supported by appropriate housing, medical facilities, equipment and processes; and
- timely access to prescribed medications, treatment modalities, specialists and appropriate levels of care.

Accomplishing the mission is a huge challenge only because of the current chaotic state of CDCR's medical delivery system. Timely access is not assured. The number of medical personnel has been inadequate, and competence has not been assured. Accurate and complete patient records are often not available when needed. Adequate housing for the disabled and aged does not exist. The medical facilities, when they exist at all, are in an abysmal state of disrepair. Basic medical equipment is often not available or used. Medications and other treatment options are too often not available when needed. Custody resources needed to facilitate access to care and provide the security necessary to deliver health care safely in a prison setting are inadequate, lacking both the personnel and structure to ensure timely access to health care services. Indeed, it is a misnomer to call the existing chaos a "medical delivery system"—it is more an act of desperation than a system.

This is not intended to be a criticism of the hard work done on a daily basis by thousands of health care professionals within CDCR. The truth is that these professionals are struggling to provide care in a chaotic environment where treatment encounters are largely episodic, accurate [3] patient information is often not available and follow-up care cannot be taken for granted. Adequate medical care requires much more than individual effort—it requires organizational leadership, effective management, coordinated planning, and execution by health care and custody teams, all of which has been lacking. More than anything else, this plan establishes a roadmap to bring order to CDCR's medical program:

moving from— chaotic care that is largely episodic; and consists of often untimely and uninformed encounters between patients and clinicians;

moving to — a system of proactive, planned, informed, patient-centered, and professional care.

[4] Strategic Goals

As noted above, our mission is a simple one: Reduce avoidable deaths and illness by giving patient-inmates

- timely access to competent medical and clinical personnel who provide effective care informed by accurate patient records and supported by appropriate housing, medical facilities, equipment and processes; and
- timely access to prescribed medications, treatment modalities, specialists and appropriate levels of care.

To fulfill this mission, our strategic goals focus on the following:

1. Ensure Timely Access to Care,
2. Improve the Medical Program,
3. Strengthen the Health Care Workforce,
4. Implement Quality Assurance and Continuous Improvement,
5. Establish Medical Support Infrastructure, and
6. Provide Health Care and Health Care-Related Facilities.

These goals encompass key aspects of CDCR's health care delivery system. We are coordinating our planning and implementation with CDCR's mental, dental and health care accessibility programs, and as we move increasingly from planning into execution, we should see improvements in CDCR's overall health care program.

A brief word about implementation strategy is warranted here. As reflected in this strategic plan, the Receiver is undertaking an extraordinarily broad organizational change effort within CDCR's health care program. We are touching, changing and improving virtually every element of that program—and in many areas, creating capacity that does not exist at all today. In these circumstances, a proven change methodology is essential. We have adopted, and will continue to follow, the organizational change strategies suggested by the Institute of Medicine (*Crossing the Quality Chasm, A New Health System for the 21th Century*, Washington D.C., National Academy Press, 2001), strategies the Institute considers essential to safe, effective and efficient health care:

1. Redesign of care processes based on best practices.
2. Information technologies for clinical information and decision support.
3. Knowledge and skills management.
4. Development of effective teams.
5. Coordination of care across patient conditions, services and settings over time.
6. Incorporation of performance and outcome measurements for improvement and accountability.

[5] Goal 1. Ensure Timely Access to Health Care Services

Health care services are meaningful only if patient-inmates have timely access to appropriate services. The initial assessment of health care needs occurs during the process of reception and intake (where inmates first enter the CDCR system). The Receiver will redesign and standardize this initial assessment process. Once within the CDCR system, access to health care will be improved by creating health care access units to facilitate patient-inmate movement to on-site clinics and to off-site care, and the Receiver will work with CDCR to speed the delivery of an inmate scheduling and tracking system so that the health care system can properly locate patient-inmates.

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Intake screening and assessment is done inconsistently throughout the system. Medication mishaps at reception alone are responsible for significant morbidity and mortality. Efforts at some reception centers (e.g., San Quentin) have led to streamlined integration of medical, mental health, and dental screening with more appropriate use of resources and improved quality of care. Even at San Quentin, however, workflows will need to change in response to changes in the pharmacy and laboratory processes as well as improved computer systems. There is a pressing need to redesign and standardize reception center processes and ensure statewide implementation. This standardization must be done prior to implementation of electronic record systems. It will serve as a first step toward appropriate identification and assessment of high-risk patients, development of utilization/case management systems, and facilitation of electronic quality monitoring.

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation

Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Health care services are meaningful only if patient-inmates have timely access to those services. In a correctional setting, issues of access are inextricably intertwined with control and supervision of inmate movement by custody staff. System-wide, CDCR lacks the custody staff and organizational structure and processes to ensure that patient-inmates are reliably escorted and/or transported to medical appointments. As a result, patient-inmates are often denied timely access to health care services, substantially increasing the risk that patient-inmates' health will further deteriorate and increasing the overall costs of providing health care services.

[6] To ensure timely access, CDCR will establish dedicated health care access custody teams—to be known as "Health Care Access Units"—at each institution whose primary mission will be to ensure access to health care, both in-prison and out-of-prison, consistent with professional standards of custody management.

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of *custody operations and their influence on health care access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution*

The Receiver has already concluded preliminary assessments at over two-thirds of CDCR's institutions. The institutions are working closely with the Receiver and are embracing the concept of Health Care Access Units in response to the Receiver's recommendations. We expect the preliminary staffing review relating to health care access operations inside all the institutions to be completed by January 2009.

Action 1.2.2 By July 2011, the Receiver will have fully implemented Health Care Access Units and developed health care access processes at all CDCR institutions

Ensuring access requires more than just staffing Health Care Access Units. Currently there are no standard policies, processes or procedures for how those units would actually ensure that a patient-inmate gets timely access to health care. In the corrections context, those policies and procedures must be developed to ensure that transport is accomplished in a safe and efficient manner. In addition, we must develop standards and processes for measuring our performance on access to care.

The Receiver will develop policies and measurement approaches that are appropriate to the type of institution and access that is needed. For example, access procedures will certainly differ depending upon whether the need for access arises in a reception context or involves sick call, chronic care, specialty care, infirmary care or acute care.

The staffing, organizational structure and operational policies and procedures for Health Care Access Units will be fully developed and implemented at all CDCR institutions by July 2011, contingent upon recruiting and training sufficient numbers of correctional officers to fill the new health care access posts.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

The Health Care Access Units created pursuant to Objective 1.2 will be most effective when there is a health care scheduling and patient-inmate tracking system. Currently there is no system in place that efficiently and effectively is able to schedule medical appointments and track the location of patient-inmates as a medical appointment approaches. The result is an enormous waste of precious clinical treatment slots as large numbers of appointments are missed, either because conflicts develop on the calendar or, more frequently, because the patient-inmate is moved without timely notification to the health care provider. The Receiver needs to implement [7] a health care scheduling system encompassing medical, mental and dental which is linked with a patient-inmate tracking system.

Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables

The Legislature has already approved and provided funding for CDCR to develop the Strategic

Offender Management System ("SOMS"). SOMS will provide an automated system to replace manual paper files and improve and standardize population management practices statewide. It will also consolidate the functionality of multiple existing inmate and parole automated systems into a single integrated solution with an enterprise database. CDCR is nearing completion of the work to release an RFP.

The SOMS project includes an adult offender tracking system which, with appropriate modifications, could satisfy the Receiver's needs for a healthcare tracking and scheduling system. Recently, the Receiver and CDCR agreed to explore whether, with the Receiver's assistance, CDCR could deliver the inmate scheduling and tracking system on a significantly accelerated time table. This approach will avoid the expense and added complexity of having the Receivership acquire a separate scheduling and tracking system.

Objective 1.4. Establish A Standardized Utilization Management System

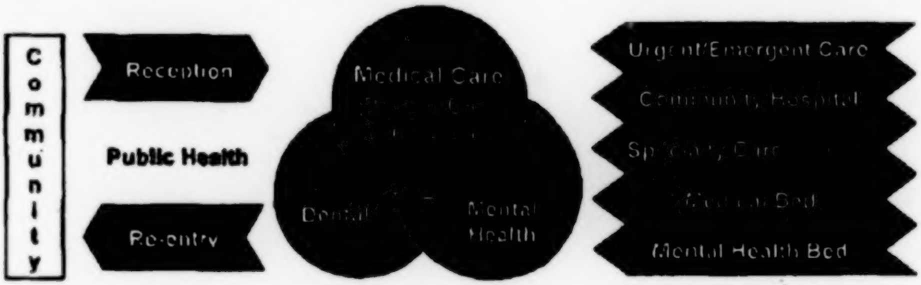
Utilization management (UM) aims to ensure appropriate access to specialty services, infirmary beds, and hospitalization. The Receiver's centralized utilization management system will provide interdisciplinary, criteria-based decision-making based on patients' illness and needs, supported by information technology and a data analysis unit. As part of this development effort, the Receiver will accelerate current efforts to ensure that patients have appropriate access to needed care. The first step will be to undertake statewide medical bed sweeps to identify those patients who have needs that cannot readily be met in their current location. We anticipate discovering a large population of patients who have long-term care needs, and to provide a destination for those patients pending construction of the permanent long-term chronic care facilities described in Goal 6, we will increase long-term care capacity at an existing facility.

> *Action 1.4.1. By January 2009, open long-term care units at one facility as a pilot project to assist in developing plans for other long-term chronic care facilities*
>
> Initiate a long-term chronic care pilot at California Medical Facility by converting one Outpatient Housing Unit to a Correctional Treatment Center and by converting two General Population Units to Outpatient Housing Units.
>
> *Action 1.4.2. By October 2010, establish a centralized Utilization Management System*

The Utilization Management System will facilitate interdisciplinary, criteria-based decision-making based on patients' illness and needs, supported by information technology and a data analysis unit.

[8] Goal 2. Establish A Prison Medical Program Addressing The Full Continuum of Health Care Services

The following is a simplified schematic of the prison medical care system:


Community
Reception
Public Health
Re-entry
Medical Care
Dental
Mental Health
Urgent/Emergent Care
Community Hospital
Specialty Care
Medical Bed
Mental Health Bed

Considerable work remains to be done in each of these domains as well as in others not shown, e.g., receiving and release, each of the clinical disciplines, and the custody, information technology, and other support functions discussed elsewhere in this document. Goal 2 addresses primary care, chronic care, specialty and hospital care, and emergency response.

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

In the prison system, access to primary care is generally through a "sick call" process. While the sick call process would appear to be more straightforward than reception, it too is plagued by inconsistent local processes involving too many forms, handoffs, and opportunities for error. Nurses and physicians often make decisions about patients without access to critical information and past assessments and depend upon a downstream paper referral system for tests and follow-up, a system that is inefficient and treacherous. Nursing protocols have lacked appropriate review, revision, oversight and support. Harmful delays and disruptions in care often involve errors in the sick call and follow-up process. The lack of any effective electronic scheduling and tracking system makes it easy to "lose" patients and makes it difficult to measure compliance with access-to-care standards. These system problems make it virtually impossible to provide proactive, planned care to our patients.

Action 2.1.1. By July 2009, complete the redesign of sick call processes, forms, and staffing models

Action 2.1.2, By July 2010, implement the new system in all institutions

[9] *Objective 2.2.* Improve Chronic Care System to Support Proactive, Planned Care

A review of all inmate deaths during 2006 revealed that 17% of those deaths (66 out of 381) were preventable or possibly preventable if proper medical care had been provided. Of those 66 deaths, 18 (27%) were preventable, and 48 (73%) were possibly preventable.

The leading cause of preventable deaths during 2006 and 2007 were chronic conditions. In 2006 the leading cause was asthma, typically an acute asthma attack that was not properly treated (6 of 18 or 33%). The annual rate of death from asthma in California's prisons in 2006 (35 per million) was 250% higher than the annual rate of death from asthma in the general population (14 per million).

The significantly higher rate of death from asthma in California's prisons is attributable to basic failures across the spectrum of chronic care, including failure of clinicians to follow published guidelines and standards of care, failure of RNs to triage sick asthmatics to an MD, failure to ensure timely follow-up, a failure to appreciate the volatility of symptoms, failure to ensure timely follow-up, non-existent tracking systems, and a broken emergency response system.

The Receiver has taken steps to educate all clinicians and custody personnel regarding the seriousness of access to care for patient-inmates who are suffering from asthma. These include death reviews, action against 62 practitioners, establishing statewide clinical leadership, and new tools such as asthma medication guidelines.

These focused steps appear to have dramatically improved the problem of avoidable deaths from asthma. According to preliminary analysis of deaths during 2007, there was only one possibly preventable death from asthma. However, the problem of improving chronic care plainly remains since the leading cause of preventable and possibly preventable deaths in 2007 is another chronic condition, cardiovascular disease.

> *Action 2.2.1. By April 2009, complete a comprehensive, one-year Chronic Care Initiative to assess and remediate systemic weaknesses in how chronic care is delivered*
>
> A variety of systemic access-to-chronic-care failures contributed to the high number of preventable deaths from asthma. In February 2008, the Receiver approved an initiative to assess failures in chronic care and implement a program of remediation to address conditions such as: cardiovascular disease, diabetes, immune system impairment (including HIV), liver disease, and asthma. The remediation program will develop improved systems for managing chronic illness, including use of team-based rather than physician-centric approaches, care coordination across settings, performance measurement, and information technology.

[10] *Objective 2.3.* Improve Emergency Response to Reduce Avoidable Morbidity and Mortality

Each institution within CDCR has developed its own internal medical emergency response system, and many of these systems do not meet community standards. As a result, CDCR facilities are not uniformly prepared to handle basic medical emergencies resulting in failures of Care, delayed transport and poor outcomes for inmates and staff.

The basic elements of an emergency response system include:

- Planning and policy development,
- Training in emergency response, and
- Acquisition and placement of appropriate emergency response equipment.

Action 2.3.1. Immediately finalize, adopt and communicate an Emergency Medical Response System policy to all institutions

The Receiver's team has completed work on a new Emergency Medical Response System policy. The policy clearly specifies the roles of the first responder, health care staff and custody personnel in reacting to an emergency medical situation.

Within 60 days, that policy will be adopted, and the substance of the policy will be communicated to all health care and custody staff to improve access to appropriate care in emergency situations.

Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff

Adoption of policy, the focus of Action 2.4.1, is only the first step in establishing a robust emergency response system. For the policy to be effective, all clinical staff must receive appropriate training in basic emergency response skills. The Receiver's team will develop and implement certification standards for emergency response including a requirement that all medical personnel be certified in CPR, one of the key components of effective emergency response.

Action 2.3.3. By January 2009, inventory, assess and standardize equipment to support emergency medical response

The final element in effective emergency medical response is the ready availability of appropriate emergency medical equipment. This type of equipment is not uniformly available at CDCR institutions. By July 2008, we will have completed an inventory and assessment of EMR equipment within CDCR. By January 2009, we will have acquired standard EMR equipment for all CDCR institutions.

[11] *Objective 2.4.* Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality

Specialty care and hospitalization of patient-inmates is generally provided by contract with specialty care and/or hospital providers. Access is through transport to out-of-prison specialty care providers and hospitals, or by utilizing telemedicine technologies. Objective 2.4 focuses on the policy and contract aspects of providing specialty and hospital care. Access by transport is the subject of Goal 1.3, and access by telemedicine is encompassed within Objective 5.5,

Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals

CDCR does not have standardized processes or policies for referral of patient-inmates to specialty care providers or hospitals. The result is inconsistent access to specialty care and hospitals that varies from institution to institution.

The Receiver's clinical leadership will develop standardized processes and policies for specialty care and hospital utilization.

Action 2.4.2. By July 2009, establish on a statewide basis approved contracts with specialty care providers and hospitals

Contracts to provide specialty care and hospitalization services have generally been negotiated on an institution-by-institution basis. The result has been inconsistent and weak procurement practices and results, and a failure to benefit from the full range of specialty service and hospital providers that are available on a statewide basis.

The Receivership will establish a specialty care and hospital provider contracting program at a statewide level. This will result in more cost-effective contracts with specialty care and hospital providers, as well as improved access to these services at CDCR facilities.

Action 2.4.3. By July 2009, ensure specialty care and hospital providers' invoices are processed in a timely manner

CDCR does not have a history of paying invoices in a timely manner. The cost of not being a good purchaser who timely pays for services rendered includes providers simply refusing to do business with CDCR. Although these problems with individual specialty providers or hospitals usually get resolved, the inconvenience, administrative cost and delays interfere with CDCR's ability to secure timely, cost-effective specialty care and hospital services.

By July 2009, payment of specialty care and hospital provider invoices will be made on a timely basis 98% of the time.

[12] Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

CDCR has had great difficulty recruiting, training and retaining a professional quality medical care workforce. The quality of care directly suffers. The Receiver will pursue three broad initiatives to improve the quantity and quality of health care workers:

- Recruiting of physicians, nurses and other clinicians with a goal of filling 90% of established positions,
- Establishing a professional training program, and,
- Creating and staffing a health care leadership and management structure.

Objective 3.1. Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

Action 3.1.1. By January 2009, fill 90% of nursing positions

Medical care in the prison system is primarily mediated by the nursing staff. Faced with a severe shortage of qualified nurses, during 2007, the Receiver converted the existing peace officer Medical Technical Assistants ("MTAs") to Licensed Vocational Nurses ("LVNs") and embarked upon an aggressive recruitment campaign to fill those positions. As of February 2008, the vacancy rate for LVNs is approximately 29%. A stipulation between the State and the Receiver was entered into in January 2008 that allows for the hiring of LVNs at various rates within the salary range based on each LVN's work experience. This change should assist in bringing the LVN vacancy rate down considerably in the coming months. Our target is a 10% vacancy rate by January 2009.

Action 3.1.2. By January 2009, fill 90% of physician positions

The severe shortage of competent medical personnel within CDCR extends to the ranks of its primary care physicians. While increasing physician compensation in 2007 has resulted in some improvement in CDCR's ability to attract doctors, more needs to be done to reach the target of having 90% of physician positions filled by January 2009.

The Receiver has recently given the green light to a substantial recruitment effort focused on attracting quality physicians to CDCR. Results from the effort should be apparent in the fourth quarter of 2008. Recruiting and retaining physicians in certain parts of the State—such as certain areas of the central valley—will remain as challenging for CDCR as it currently is for private sector health care providers. As noted elsewhere in this plan, the Receiver intends to expand the utilization of telemedicine technologies to partially compensate for some of the recruitment challenges we are sure to face.

[13] *Objective 3.2.* Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2009, establish and staff new executive leadership positions

The Receiver has worked with the State Personnel Board to establish appropriate classifications, first for Nurse Executives, then for Physician Executives. In coordination with the Department of Personnel Administration, the Receiver recently engaged CPS Human Resources Services to conduct a compensation survey to assist the Receiver in determining appropriate compensation levels for these positions. The Receiver will meet with DPA and other departments in the Executive Branch that employ nurses and physicians to ensure that the Receiver's approach to these classifications is coordinated with those other departments. The Receiver intends to fill 90% of the Nurse Executive positions by January of 2009. The Receiver has also worked with the Special Master in *Coleman*, and the Court Representatives in *Perez* and *Armstrong* to create a Chief Executive Officer (CEO) pilot program. Health care services at each of the three pilot institutions will be administered by a single CEO responsible for directing the entire health care program at the institution, including medical, pharmacy, nursing, mental health and dental services.

Action 3.2.2. By January 2009, establish and staff regional leadership structure

The Receiver will analyze options for allocation of functions and responsibilities at three levels: statewide, regionally and at the institution. It is important to identify those functions that can most efficiently and effectively be performed by centralizing them statewide. Likewise, coordination at the regional level is essential, particularly as the Receivership is initiating fundamental change throughout the system.

Objective 3.3. Establish Professional Training Programs for Clinicians

> *Action 3.33. By January 2009, establish statewide organizational orientation for all new health care hires and institution-specific clinical orientation through a nursing preceptor or proctoring program*
>
> CDCR has no consistent orientation program or practice for its new health care employees, and none of its individual facilities has a formalized preceptor or proctoring program. These are basic elements in establishing a culture of organizational quality in a health care program. In most health care settings, employees receive an introduction to the organization through a standardized orientation process starting on day one of employment. The best practice is to follow the organizational orientation with a comprehensive preceptor or proctoring program (i.e., a "clinical orientation") for clinical staff.
>
> The Receiver has piloted the content and format for orientation at three CDCR institutions. Based on participants? feedback and lessons learned, the Receiver will roll out new orientation programs to all institutions within a given region (i.e., Northern, Central and Southern). This regional orientation approach allows us to include all 33 CDCR institutions in the new orientation program by January 2009.
>
> [14] Beyond lacking orientation, CDCR clinicians have been working with little professional support in remarkably dispiriting environments. Prisons are a vital part of the health care safety net, along with public hospitals, community clinics,

and the Veterans Health Administration, and the Receiver has had success in recruiting clinical change agents into CDCR. To retain these clinicians and to sustain improvements in quality, however, it is critical to establish professional expectations and support. The Receiver has established new programs for nurses, mid-level providers, and physicians and has begun to deploy web based decision support at the point of care.

Action 3.3.2. By January 2009, win accreditation for CDCR as a CME provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education

The new Continuing Medical Education Committee has been charged with infusing adult education principles and evaluation throughout the system. The Receiver is also creating formal leadership programs for deployment this year.

[15] Goal 4. Implement Quality Improvement Programs

As noted above, the Institute of Medicine identified one of its six essential strategies for health care transformation as "the incorporation of performance and outcome measurements for improvement and accountability." These measurements become the basis for a continuous quality improvement program throughout the prison health care system. Development of this program requires not only new policies and procedures, but a fundamental culture change and the development of skills for clinicians, clinical units, institutions and the entire system to self-assess and self-correct.

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

Sustaining a program of organizational improvement is possible only if organizational outcomes are routinely measured, evaluated and analyzed. Then, steps must be taken to adjust organizational resources, processes and practices to improve those outcomes. There must be "feedback loops" that encourage best practices and a culture of accountability that discourages noncompliant behavior. Currently in CDCR, timely, accurate data about outcomes is virtually non-existent and there is no quality management infrastructure in place.

Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs

The Receiver is now recruiting leadership for a new Quality and Safety Branch which will support performance measurement, quality improvement and patient safety initiatives in service of accountability and effectiveness. This group will be responsible for developing the metrics by which performance will be assessed.

Quality measurement and evaluation depend upon access to timely, accurate and relevant data. Today, the infrastructure for collecting that data simply does not exist within CDCR. As various statewide information systems are developed, we will increasingly be able to report on relevant outcome measures.

The ultimate goal, which may not be achieved for three years, is to develop balanced scorecards showing each institution's disease burden, utilization, staffing, access-to-care measures, clinical quality indicators and financial performance.

Action 4.1.2. By July 2009, work with the Office of Inspector General to establish an audit program focused on compliance with Plata requirements

Working with the Receiver, Prison Law Office and the State's representatives, the Office of the Inspector General has begun to establish an audit process of clinical performance in CDCR facilities. The process will be piloted in five facilities during the first six months of 2008. The results of the pilot will be used to improve the process. With the consent of the Court, the inspection program will then be rolled out to all CDCR facilities.

[16] *Objective 4.2.* Establish a Quality Improvement Program

Quality improvement is a hallmark of a well-run health care system. Using information from measurement and evaluation systems (see Objective 4,1 above), as well as self-assessment and other sources of ideas for improvement, the health care system works on a continuous basis to improve both its efficiency and its outcomes. Improvements in clinical processes will also require updating of clinical policies and procedures.

Action 4.2.1. By September 2009, train and deploy a cadre of quality improvement advisors to develop model quality improvement programs at selected institutions. .

Action 4.2.2. By September 2009, establish a Policy Unit responsible for overseeing review, revision, posting and distribution of current policies and procedures.

As noted above, the ability to incorporate improvements into policies and procedures is key to standardizing those improvements within an institution, and support the system's ability to implement those improvements, with adjustments as necessary, at other institutions.

Action 4.2.3. By January 2010, implement process improvement programs at all .institutions involving trained clinical champions and supported by regional and statewide quality advisors

To build a culture of continuous quality improvement requires not only systems and procedures, but also training and development of clinical and support staff. By January 2010, the Receiver will have in place the leadership structure, including clinical champions at the institutional level and quality advisors at the regional and statewide level, and will have developed the capability and commitment of staff to implement a system-wide quality improvement program.

Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Peer review is the gold standard when it comes to maintaining and improving the performance of health care professionals and the quality of care. Peer review is a process whereby medical professionals evaluate the performance of other professionals in a health care organization and provide remediation or, in the most extreme cases, limit or terminate privileges to practice within the organization.

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an *effective Peer Review and Discipline Process to improve the quality of care*

CDCR has not had an effective peer review and discipline program. As a result, there has been little professional pressure or support to improve quality of care. Incompetent practitioners have been allowed to remain paid state employees even after the CDCR has removed their privileges to practice within the system.

[17] Because peer review processes can lead to the suspension of privileges, and the conduct giving rise to peer review can at times overlap with conduct that would support disciplinary action, the Receiver will work with the State Personnel Board to establish a peer review process that serves the dual goals of improving quality of care by having professionals review each other's practice and ensuring that the processes of peer review, if it leads to a suspension or termination of privileges or to adverse discipline, are conducted fairly and consistently with State law. The Receiver will coordinate this program with other departments that provide direct medical services.

Working with the State Personnel Board, the Receiver intends to establish a peer review and discipline program on a statewide basis by July 1, 2008.

Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

Preliminary work has already begun on a pilot of the Medical Oversight Unit. An Investigation and Discipline Coordinator currently monitors all health-care investigative and disciplinary activity. A statewide tracking system for health care-related investigations of misconduct by health care and correctional staff has been implemented. Institutions are required to provide a monthly Investigation and Discipline Audit Report on all cases involving medical employees.

Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations

Physicians and nurses will be trained to do investigations. The Medical Oversight Unit will be led by a Chief Medical Officer working with a lead nurse and reporting to the Clinical Operations Branch Chief, who reports directly to the Receiver's Chief Medical Officer, The lead clinicians of the Medical Oversight Unit will be responsible for leading Central Intake Unit discussions involving clinical incidents. Representatives from the Office of Internal Affairs and the Employment Advocacy Prosecution Team will participate in those weekly discussions. The Office of the Inspector General's Bureau of Independent Review has agreed to conduct independent oversight of the new units. The Medical Oversight Unit commenced operation in January 2008.

Goals of the Medical Oversight Unit include:

- Improving patient safety by identifying and addressing misconduct among staff in the CDCR medical care system;
- Reducing the potential of lawsuits by addressing misconduct in a thorough, timely and judicious manner;

- Increasing the success of appropriate employee discipline, reducing the number of overall appeals, enhancing settlement prospects and reducing civil litigation,

[18] *Objective 43.* Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

Disputes can arise in individual cases whether or not there has actually been appropriate and adequate access to care. As a result, health care organizations have processes to resolve patient complaints regarding access to care.

In CDCR, patient-inmates concerned about their access to or the quality of medical care may file an appeal pursuant to Title 15 of the California Code of Regulations and/or file petitions for a writ of habeas corpus. However, CDCR lacks a coordinated system for tracking and responding to complaints about access to care. Absent such a system, complaints about access are at risk of being misplaced or mishandled.

> *Action 4.5.1. By July 2008, centralize management over all health care patient-inmate appeals, correspondence and habeas corpus petitions*
>
> The first step in improving health care appeals is to consolidate the management of all appeals, correspondence and health care-related habeas corpus petitions. Consolidation has the greatest potential to quickly improve how disputes about health care access are resolved.
>
> By July 2008, we will have consolidated all patient-inmate health care inquiry functions (including controlled correspondence, correspondence addressed to the Receiver, Prison Law Office inquiries, Inmate Health Inquiry Hotline

calls, Health Care Appeals and Petitions for Writs of Habeas Corpus) into one unit and established more consistent, comprehensive and timely inquiry response systems.

Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide analysis of the statewide appeals process and will recommend improvements to the Receiver

To improve the consolidated system, we have established a task force of stakeholders (including clinical staff, counsel and correctional staff) to conduct a system-wide analysis of the current statewide appeals process. The task force is in the process of conducting an analysis of the current system to determine best practices and make recommendations to the Receiver for further improvements. Certain remedial programs (e.g., the transfer of Third Level Appeals from custody analysts to health care analysts) are being implemented at this time.

The Task Force's report to the Receiver is due by August 2008.

Objective 4.6. Establish Out-of-State, Community Correctional Facilities and Re-entry Facility Oversight Program

Thousands of CDCR prisoners are now being housed in out-of-state, community correctional or re-entry facilities that are not subject to CDCR's day-to-day control and management. The health care of these prisoners remains a subject of concern to the Receiver.

[19] *Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in*

out-of-stat, community correctional or re-entry facilities

The Receiver will establish an administrative unit with responsibility for conducting medical oversight of entities that, by contract with CDCR, house and care for CDCR inmates. Oversight includes establishing clinical standards and health care staffing standards for out-of-state community correctional and re-entry facilities, managing contract modifications with these entities to ensure compliance with remedial orders of the federal courts, and establishing and implementing an inspection protocol and schedule. The oversight program has been established and will be fully operational by July 2008.

[20] Goal 5. Establish Medical Support Infrastructure

The Receiver's primary attention in its first eighteen months has been to plan and begin implementing the core elements of a medical program, which have included improving the quantity and quality of medical and clinical personnel within the system and improving access to care. As plans for those elements have materialized, it is now time to turn more attention to planning and activities to improve the secondary services that surround and support health care delivery systems. These secondary services include such things as:

- Pharmacy,
- Medical Records,
- Radiology Services,
- Laboratory Services, and,
- Telemedicine.

Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program

There has been no effective management of CDCR's pharmacy program. The predictable result has been a huge waste of public funds which cuts into expenditures for other important aspects of CDCR's health care system. Ineffective acquisition practices have resulted in the State overpaying for pharmaceuticals, and the failure to establish an approved formulary—a critical first step in creating a program of managed care—has resulted in some of the most expensive drugs being prescribed when less expensive, but equally efficacious, alternatives are available.

The Receiver has contracted with a nationally-known provider of pharmacy services, Maxor National Pharmacy Services Corporation, to assist in establishing a comprehensive, modern pharmacy program throughout CDCR. There are three key elements to the program:

- Establishing a drug formulary to standardize and improve quality of care at reduced cost;
- Improving and standardizing pharmacy policies, practices and support at each institution; and,
- Establishing a central-fill pharmacy to manage inventory.

At the same time the system is experiencing increased access to care and a resulting higher demand for pharmaceuticals, with proper management of the elements above (i.e., more cost-effective acquisition of drugs, and system-wide cooperation and implementation of the drug formulary), the pharmacy program is expected to achieve significant cost avoidance in pharmaceutical expenditures. Expenditures are estimated to be $33 million lower in 2008 than what costs would have been if the prior trends had been allowed to continue without change.

> [21] *Action 5.1.1. Continue developing the drug formulary for the most commonly prescribed medications*
>
> One of the cornerstones of managing costs in a managed care system is utilization of a drug formulary to guide physicians in selecting prescriptions. The Receiver has reconstituted a revitalized CDCR Pharmacy and Therapeutics Committee ("P&T Committee") that meets monthly to review policies and procedures.
>
> Among other things, the P&T Committee has begun to develop and adopt a standardized CDCR Formulary. The P&T Committee has developed disease medication management guidelines for the following common conditions:
>
> - Hypertension and Hypertension Urgency
> - Asthma (acute and chronic)
> - Diabetes (type 1 and type 2)
> - Hyperlipidemia
> - HIV
> - Seizure (acute and chronic)
> - Hepatitis C (currently pending final approval)
> - Gastroesophageal Reflux Disease (GERD)/ Peptic Ulcer Disease (PUD)
> - Schizophrenia (acute and chronic)

- Chronic Obstructive Pulmonary Disease (COPD)

As a result of the initial implementation of this program, non-formulary costs per member per month have declined in the last half of 2007 from $29.01 *to* $14.66, while formulary costs per member per month have increased only slightly from $73.64 to $74.75 (while costs for prescription drugs nationally rose 4.2% in 2007).

The P&T Committee will continue to conduct therapeutic category reviews as part of the formulary program. The savings from this active management will be substantial. For example, when data on drug utilization was collected and presented, the P&T Committee immediately noticed that almost 70% of total statin purchases were for Lipitor (atorvastatin). The P&T Committee decided in June 2007 to adopt simvastatin (generic Zocor) for the CDCR drug formulary. Utilization of Lipitor dropped dramatically over the course of the next several months, while utilization of simvastatin rose. This single decision has resulted in a cost avoidance of more than $400,000 per month.

A clinical pharmacy service to assist health care providers with formulary compliance, appropriate medication management and patient intervention has been developed and is being extended to facilities statewide.

Action 5.1.2. By June 2009, improve pharmacy policies and practices at each institution and complete the rollout of the GuardianRx system

Working closely with Maxor, the Receiver has taken a number of quick steps to improve the operations of institution-based pharmacies. The Receiver will continue these system-wide program improvements.

[22] Fully staffing the pharmacy function has been a top priority. The Receiver has approved 10 new pharmacist and 3 new technician positions. The number of registry pharmacists-in-charge has been reduced from 10 to 6, and one site with no pharmacist-in-charge has been staffed. In addition, personnel training and competency programs have been established to ensure compliance with revised policies and practices.

Pharmacists and pharmacies do not work in isolation from the professionals who direct patient care. To ensure coordination, the Receiver has established Pharmacy Nursing Liaison staff to work with nursing leadership on medication management processes. This has resulted in improved communication and coordination with nursing staff.

Maxor has started employing a pharmacy services "drop-in" operations team to provide immediate, intensive attention to facilities experiencing significant pharmacy system issues. To date, the drop-in teams have assisted 17 of the 33 prison facilities.

Finally, Maxor has now successfully rolled out the GuardianRx system as an interim operating system in four prisons. By the end of 2008, GuardianRx will be functional in 26 prisons and in all facilities by June of 2009. Its statewide implementation will provide a strong basis for improving pharmacy performance, enforcing policies and standards, such as "the formulary, managing pharmaceutical inventory and collecting reliable utilization data.

Action 5.1.3. By February 2009, establish a central-fill pharmacy

Building a central-fill pharmacy from which nearly all drugs will be acquired will substantially improve CDCR's ability to control and cost-effectively manage its drug inventory and utilization. The Receiver is working with CDCR and the Department of General Services on the development of sites for the proposed centralized pharmacy facility. Maxor continues to develop the minimum specifications required and through the services of DOS space planning and design teams, will work with property owners to develop a build-out plan.

We expect the central-fill pharmacy to be operational by February 2009.

Objective 5.2. Establish Standardized Health Records Practice

CDCR lacks a uniform, standardized health information system and lacks functional centralized oversight or management of health care recordkeeping. The Receiver is seeking external assistance to establish an effective management system that ensures standardized health records practice in the California prison system.

Action 5.2.1. By February 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions

> CDCR is in the initial planning stages for system-wide computerized patient information systems for all inmates. If these systems are to be implemented in a timely and efficient fashion, paper-based health records processes and clinical documentation at all CDCR facilities will first need to be standardized and streamlined.

[23] *Objective 5.3.* Establish Effective Radiology and Laboratory Services

Last year, the Receiver engaged consultants to assess CDCR's medical records, radiology and laboratory programs and to make recommendations for improvements. The report on laboratory services is due to be received by mid-2008. The work on medical records is scheduled to begin Spring 2008. The report on radiology services is due to be received by July 2008. After reviewing these reports, the Receiver will decide upon a strategy to improve radiology and laboratory services.

> *Action 5.3.1. By August 2008, decide upon strategy to improve medical records, radiology and laboratory services after receiving recommendations from consultants*

Objective 5.4. Establish Clinical Information Systems

CDCR's information technology systems are a shambles, although there is real hope for the future. Until fiscal year 2007-2008, there had been no strategic investment in CDCR's information systems for decades. As a result, CDCR did not have a statewide network, its desktop systems and applications were not connected, and many of the critical applications were nearing or already past their life expectancy. Last year, CDCR presented to the Legislature, and the Legislature funded, a portfolio of information technology projects that promises to bring CDCR's information systems into the 21st century. The Receiver is closely coordinating his activities with the development of these systems, many of which are of critical importance to the delivery of health care.

> *Action 5.4.1. By July 2009, establish a clinical data repository available to all institutions as the foundation for all other health information technology systems*
>
> Because the Receivership had already been created, CDCR did not propose to the Legislature last year any core medical information technologies. The most important medical system is a clinical data repository which will serve as the primary database for CDCR's health care system. It will be through the data repository that patient-inmate health records can be established, radiology and laboratory results can be communicated, and the initial steps towards building a digital health care system can be taken.
>
> The Receivership is nearing completion of its statewide network infrastructure. We are also nearing the award of a contract for an integrator to assist in implementing the medical data repository. We expect the repository to be functioning by no later than July 2009.

Objective 5.5. Expand and Improve Telemedicine Capabilities

Telemedicine is being used very effectively by prison health care systems around the country. CDCR is lagging far behind as a result of the absence of strong leadership to nurture the program as well as insufficient telemedicine infrastructure to support a significantly expanded telemedicine program.

> [24] *Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure*
>
> The Receiver will put in place strong leadership within the telemedicine program with a direction to upgrade CDCR's telemedicine technologies, assess and expand staffing as appropriate and engage with the University of California system and others to establish a vastly expanded telemedicine program.

[25] Goal 6. Provide for Necessary Clinical, Administrative and Housing Facilities

The facilities available for providing health care services within CDCR are woefully inadequate. Through years of neglect, the facilities have long since passed the time when modest investments could remedy the problem. We are dealing not with deferred maintenance, but with some facilities that are literally falling apart. In addition, investments in health care facilities have significantly lagged behind growing inmate populations, so much so that available clinical space is less than half of what is necessary for daily operations.

The only cost-effective remedy is to improve and/or build new administrative and clinical facilities at each of CDCR's 33 prison locations to provide local health care services. These facilities will generally include clinical treatment space, medical administration space, medical storage space and other medical support spaces such as pharmacy, medical records and medical laboratories.

In addition to these local facilities, CDCR needs to establish seven regional long-term care centers at existing CDCR institutions with administrative, clinical and housing facilities to serve up to 6% of CDCR's inmate population who have long-term medical and/or mental health needs. Approximately three-quarters of the housing at these centers will consist of open dormitory quality housing for patient-inmates with functional impairments or chronic conditions requiring ready access to health care services.

Objective 6.1. Upgrade administrative and clinical facilities at each of CDCR's 33 prison locations to provide patient-inmates with appropriate access to care

Each of California's prisons needs improved clinical space and clinical support space. The Receiver's "Construction Upgrade Program" involves undertaking assessments and planning at each institution, followed by construction according to plans.

Action 6.1.1. By January 2010, complete assessment and planning for upgraded administrative and clinical facilities at each of CDCR's 33 institutions

Assessments and preliminary planning has already occurred at the following institutions:

- Avenal State Prison
- Correctional Training Facility
- California Rehabilitation Center
- Mule Creek State Prison

By August 2008, assessments and preliminary planning will have been completed at the following institutions:

- California Institution for Men
- California Institution for Women
- Folsom State Prison
- California State Prison, Sacramento
- [26] Richard J. Donovan Correctional Facility
- California Conservation Center
- High Desert State Prison

By March 2009, assessments and preliminary planning will have been completed at the following institutions:

- Deuel Vocational Institution
- Sierra Conservation Center
- California Correctional Institution
- California State Prison, Los Angeles County
- Wasco State Prison—Reception Center
- California Men's Colony
- Salinas Valley State Prison
- Pleasant Valley State Prison

By January 2010, assessments and preliminary planning will have been completed at the following institutions:

- Chuckawalla Valley State Prison
- Ironwood State Prison
- California State Prison, Solano
- Calipatria State Prison
- Centinela State Prison

- California Substance Abuse Treatment Facility and State Prison at Corcoran
- California State Prison, Corcoran
- Valley State Prison for Women
- Central California Women's Facility
- North Kern State Prison
- Kern Valley State Prison
- California Medical Facility
- Pelican Bay State Prison

The Receiver will closely coordinate its Upgrade Program with CDCR's construction team.

Action 6.1.2. By January 2012, complete construction of upgraded administrative and clinical facilities at each of CDCR's 33 institutions

As plans are completed and funding is made available, upgrade construction projects will be authorized by the Receiver. For each project, there will be additional detailed construction planning that will be undertaken and additional pre-construction activities cleared. We anticipate that once each prison upgrade project has been approved by the Receiver, it will take another 18 to 24 months to complete the construction.

In light of the phased assessments and planning described in Action 6.1.1, construction at multiple facilities around the State should commence no later than September 2008. By the July 2009, we should have construction activities taking place in a dozen or more prisons, and this level of construction will continue until the Construction

Upgrade Program is complete, which we are targeting for January 2012.

[27] *Objective 6.2.* Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs

As a core component of the plan to bring the level of prison health care services up to constitutional standards as quickly as practicable, the Receiver will supervise the creation of expanded prison health facilities and housing for approximately 6% of CDCR's existing inmate population (i.e., approximately 10,000 inmates) whose medical and/or mental condition requires separate housing to facilitate appropriate, cost-effective access to necessary health care services.

CDCR does not have adequate clinical, administrative and housing facilities to support constitutionally adequate health care. Reports by ABT Associates Inc. and Lumetra on chronic and long-term care needs in California's prisons and by Navigant Consulting on mental health needs demonstrate the inadequacy of current facilities and document the need for expanded facilities to serve both present and future populations. Based on these reports, the Receiver will supervise construction of facilities at existing institutions to serve 10,000 inmates with medical and/or mental health needs.

Approximately half of the housing and facilities will be for medical services, of which approximately three-quarters will consist of open-space dormitories for "specialized general population" patients who have functional impairments and chronic conditions requiring ready access to health care services (e.g., advanced chronic obstructive lung disease, or wheel chair bound patients with spinal chord injuries).

Approximately eighteen percent will consist of assisted-living-quality housing for "low acuity" patients who have nursing needs (e.g., wheel chair with wounds that need routine dressing, or stroke patients who need help dressing), and less than ten percent will consist of nursing-home-quality housing for "high acuity" patients (e.g., patients with complicated wounds that need nursing attention daily, pre/post transplant, patients undergoing chemotherapy, and patients who are completely bed bound).

The other half of the housing and facilities will be for mental health services. Approximately seventy percent of this housing will consist of open-space dormitories for an "enhanced outpatient program," eighteen percent will be for high-custody enhanced outpatients, and less than fifteen fourteen percent will be for a mix of mental health crisis beds, acute beds, an intermediate care facility and a high-custody intermediate care facility.

The Receiver intends to supervise construction on up to seven sites at existing CDCR institutions, each site supporting medical and mental health services for up to 1,500 inmates. Two of the facilities will be specially designed to serve the unique health needs of CDCR's female population. Because existing facilities are operating well beyond their design capacity for all systems, the new facilities will be designed to be self-sufficient, full-service institutions for both infrastructure and support service facilities such as food service, laundry and central plant.

The initial planning focus has been almost exclusively on the facilities themselves. Planning for the operation of these long-term, chronic care facilities is just now getting underway. We expect to present to the Administration and the Legislature preliminary estimates of operational costs in time for initial consideration for the 2009-2010 fiscal year.

We will complete this objective by July 2013.

[28] *Action 6.2.1. Complete pre-planning activities on all sites as quickly as possible*

In order to complete the construction as quickly as practicable, a great deal of the planning for all of the sites will be front-loaded and done in parallel. For each of the sites, the following pre-construction planning activities must be completed:

1. Site assessment and selection,
2. CEQA review and evaluation.
3. Infrastructure review and development of remediation plans.
4. Facility planning.
5. Program delivery.
6. Obtaining Raiding.
7. Development of Program Management Plan.

Action 6.2.2. By February 2009, begin construction at first site

The key to hitting our 2013 target date for completing this objective is the commencement of construction at the first site no later than February 2009, with construction completed at that site no later than February 2011.

Since it is unknown which sites will pose what obstacles, and how quickly those obstacles can be overcome, we are pursuing preliminary planning on all sites. Whichever site is first ready for the commencement of construction will be where we begin.

Action 6.2.3. By July 2013, complete execution of phased construction program

Construction contracts will be awarded for the project at the first site in January 2009, followed by projects No. 2 and No. 3 which will roll out in three-month increments, with contract awards by April 2009 and July 2009. Because of concerns for construction industry capacity for projects of this size, the remaining four projects will roll out in six-month increments, with the seventh project awarded by July 2011 and completed by July 2013.

Objective 6.3. Complete Construction at San Quentin State Prison

There are a number of essential construction projects already underway at San Quentin State Prison, including establishing new, improved sick call units in facility rotundas, building a temporary medical building to provide needed clinical offices and space, constructing a medical supply warehouse, and constructing the San Quentin Central Health Services Facility, a state-of-the-art correctional health care center.

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility

A substantial amount of the San Quentin improvements has already been completed, including replacing parking spaces, relocation of the "walk alone" exercise yards, renovating [29] the Trauma Treatment Area, limited upgrades to certain clinics, a minor remodel of the medical records unit and receiving and release areas, and addition of a triple-wide relocatable trailer to provide office space for medical care delivery personnel.

Other construction activities will be complete by December of 2008, including construction of new personnel offices and a medical supply warehouse, expansion of clinical sick call units and the addition of a primary care/specialty medical services modular.

Action 6.3.2. By April 2010, complete construction of the Central Health Services Facility

Demolition of existing buildings is well under way, and construction of the Central Health Services Facility is expected to begin in April 2008. The building will be ready for occupancy by April 2010.

[30] Appendix A

Estimated Costs, Metrics and Timeline

The Strategic Plan contains six major goals:

1. Ensure Timely Access to Care;
2. Improve the Medical Program;
3. Strengthen the Health Care Workforce;
4. Implement Quality Assurance and Continuous Improvement;
5. Establish Medical Support Infrastructure; and,
6. Build Health Care and Health Care-Related Facilities.

The one-time capital cost for the Healthcare Improvement and Healthcare Facility Expansion projects is estimated to be $7 billion. These projects will be funded through lease revenue bonds over a 25 year period. The debt service for these bonds will begin in Fiscal Year 2010-11 and will reach the full annual amortized payment of $585 million by Fiscal Year 2013-14.

The one-time support costs for the plan are approximately $253 million over a three-year period. Of this amount, $24 million is already included in the $1.84 billion medical budget for Fiscal Year 2008-09. This leaves only $229 million in additional one-time funding that will need to be requested at this time.

The total ongoing costs for the plan are approximately $287 million. Of this amount, $248 million is already included in the $1.84 billion medical budget for Fiscal Year 2008-09. This leaves only $39 million in additional funding that will need to be requested at this time.

There remains only one significant gap in our cost estimates. We have not yet estimated costs for operating the long-term, chronic care facilities. The operational planning for those facilities is just now getting underway, and until that planning is much further along, attempting to estimate operational costs is not feasible. Given the size of the facilities, we can expect the annual operational costs to be substantial, but until the detailed planning has been done, it simply is not possible to give a credible estimate of these costs.

We are including in the tables which follow our preliminary set of metrics by which to measure our progress. For each objective and action, we will establish and report "project" metrics (e.g., schedule, scope and cost). For some actions, we already are ready to report more substantive metrics that assist in assessing the performance or value of the program in achieving fundamental organizational goals (e.g., vacancy and retention rates for recruitment objectives). We will continue developing these substantive metrics as appropriate information on program performance becomes more readily available.

[1] IN THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT
OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
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Defendants.

DEFENDANTS', PLAINTIFFS', AND INTERVENORS' JOINT STATUS CONFERENCE STATEMENT

I. INTRODUCTION

By order of this Three-Judge Court, entered May 30, 2008, the Defendants, Intervenors, and Plaintiffs were all instructed to meet and confer regarding proposed new discovery deadlines, proposed pretrial dates, and estimated length of trial. The parties and Intervenors were similarly instructed to file a joint status conference statement advising this Court of the same. Accordingly, Defendants, Plaintiffs, and the Intervenors met and conferred telephonically on June 5, 2008, and now submit the following proposed deadlines regarding discovery, pretrial dates, and estimated length of trial.

[2] II. DEFENDANTS' PROPOSAL

A. Defendants' Proposed Discovery and Pretrial Deadlines.

August 15, 2008	Last day to complete written discovery and non expert depositions.
August 15, 2008	Expert disclosures and reports due.
August 22, 2008	Last day to disclose rebuttal experts.
September 5, 2008	Last day to complete expert discovery.
September 24, 2008	Last day to file dispositive motions (*see* explanation below).
October 1, 2008	Last day to file oppositions to dispositive motions.
October 8, 2008	Last day to file replies in support of dispositive motions.

November 15, 2008	Hearing on dispositive motions.
November 3, 2008	Last day to file motions *in limine*, pre-trial briefs, and joint pre-trial statements.
November 10, 2008	Pre-trial conference and hearing on motions *in limine*.
November 17, 2008	Trial

This Three-Judge Court's May 30, 2008 Order additionally informed the parties that if they propose a dispositive motion schedule, they must advise this Court why such a schedule is necessary. (May 30, 2008 Order at ¶ 3.) Defendants contend that a dispositive motion is both appropriate and necessary because Plaintiffs' experts testified (1) that overcrowding is not the primary cause of Defendants' inability to provide constitutionally adequate medical and mental health care to Plaintiffs, and (2) that a prisoner release order is not the only means of providing constitutionally adequate medical and mental health care to Plaintiffs. As such, there are no factual disputes as to these required elements and a dispositive motion by Defendants should be granted.

B. Estimated Length of Trial.

Defendants estimate that they will require 4 days to defend both *Plata* and *Coleman* at trial.

C. Disclosure of Trial Witnesses.

Plaintiffs and Intervenors request that this Three-Judge Court require all parties to [3] disclose the names of all trial witnesses to "target discovery." Defendants are willing to disclose their trial witnesses, as Plaintiffs and Intervenors request, with the provision that all parties are limited to deposing only those witnesses listed as potential trial witnesses.

No party to this proceeding should be permitted to depose a non-testifying trial witness. In the absence of such a limitation, there can be no guarantee that the parties will truly "target" their discovery and depositions and disclosure of trial witnesses would be meaningless.

D. Site Inspections and Time to Respond to Discovery.

Defendants contend that to the extent any party seeks to conduct additional site inspections of CDCR facilities, this Court should enter a protective order prohibiting such inspections. No further site inspections are necessary as all inspections were previously completed as to Phase I issues, and any inspection with regard to Phase II issues would be irrelevant. Additionally, given the compressed schedule within which to complete discovery, file and respond to dispositive motions, and prepare for trial, inspections of CDCR facilities around the State would constitute a waste of the parties' time and resources.

Defendants further request that to the extent the provisions of the Court's October 30, 2007 order regarding discovery now apply to the consolidated proceedings and the participation of the Defendant-Intervenors, Defendants respectfully request that all parties be permitted the full 30 days contemplated by the Federal Rules of Civil Procedure within which to respond to discovery.

III. PLAINTIFFS' AND PLAINTIFF-INTERVENOR CCPOA'S PROPOSAL

On June 2, 2008, this Court ordered the parties to meet and confer regarding proposed new discovery deadlines, proposed pre-trial dates to accompany the November trial date and an estimated length of trial.

Coleman Docket 2808 at 2. The parties had a telephone conference on Thursday, June 5, 2008 to discuss these issues.

Plaintiffs and CCPOA respectfully submit this Status Conference Statement to provide proposed deadlines and to outline issues that plaintiffs' attorneys and CCPOA [4] are prepared to discuss at the June 27, 2008 Status Conference.

A. Length of Trial

Plaintiffs estimate four full days to present their evidence at trial. Intervenor CCPOA estimates one to two days for its case.

B. Plaintiffs and CCPOA's Proposed Discovery and Pre-Trial Deadlines

Plaintiffs propose the following discovery and pre-trial dates:

6/30/08	Discovery Opens (pursuant to Three-Judge Order)
8/1/08	Last day to disclose list of trial witnesses
8/15/08	Last day to disclose names and CV's of testifying experts
9/8/08	Deadline for exchanging Expert Reports
9/22/08	Deadline for Disclosure of Rebuttal Experts and Reports
9/26/08	Close of Discovery (regular)
10/13/08	Close of Discovery (expert)
10/27/08	Deadline for Joint Pre-Trial Statement and MILs (including affidavits of testifying percipient witnesses)
11/3/08	Oppositions to MILs (no replies permitted)
11/10/08	Pre-trial Conference and hearing re MILs
11/17/08	FIRST DAY OF TRIAL

Plaintiffs believe this schedule is aggressive but reasonable for all parties. With respect to defendants and the defendant-intervenors' proposed discovery deadlines in particular, they are too short. Defendants' deadlines would effectively nullify further discovery because they would not permit enough time for responses, let alone disputes over responses. This is particularly true in light of defendants' request to be relieved from the current order imposing a 21 day deadline for all written discovery responses. *Coleman* Docket 2495 at 7.

C. Plaintiffs and the Intervenors Request an Earlier Deadline to Disclose Trial Witnesses

Counsel for plaintiffs and the intervenors agree that an earlier deadline to disclose trial witnesses would help the parties to target depositions and other discovery. For that reason, plaintiffs and the intervenors request that the Court order the parties to identify trial witnesses earlier in the process to permit focused depositions. Plaintiffs and CCPOA recommend August 1 2008 as the deadline for that exchange.

[5] Plaintiffs and CCPOA do not agree with defendants that depositions of non-trial witnesses should be barred by this Three-Judge Court. Such an order would permit defendants, who possess virtually all of the discoverable information, to prevent plaintiffs from deposing parties and critical witnesses who have substantial knowledge about key matters at issue in this litigation by not designating them as trial witnesses. As the Court knows from the underlying litigation, defendants and their agents often have the most direct knowledge about the conditions and the consequences thereof. There is no doubt that having a list of trial witnesses will allow the parties

to focus their discovery, but a limit on depositions only to those identified trial witnesses would not provide the Court with a full picture of the conditions.

D. Plaintiffs and CCPOA Request that the Three-Judge Court Include the Same Procedures for Direct Testimony of Percipient and Expert Witnesses as Provided in the Original Scheduling Order

The Three-Judge Court's prior scheduling order, which was issued on October 10, 2007, mandated that direct testimony of expert witnesses will be by expert reports and no more than thirty minutes of live testimony, and that direct testimony of percipient witnesses would be through affidavit and no more than 15 minutes of direct testimony. *See Coleman* Docket 2456 at 6. Plaintiffs respectfully request that the new scheduling order contain these same provisions. In addition, plaintiffs request that the affidavits of percipient witnesses be exchanged as part of the parties' pre-trial statement.

E. Time to Respond to Written Discovery and Additional Prison Inspections

Magistrate Judge Moulds' October 30, 2007 Order requires that "responses to any discovery requests served on or after October 25, 2007 shall be due twenty-one days from the date of service." *See Coleman* Docket 2495 at 7. That Order also states: "Defendants shall provide reasonable notice to plaintiffs and to CCPOA of any prison site inspection by any defense expert and counsel for plaintiffs and CCPOA shall be permitted to attend any such site inspection." *Id.* Plaintiffs oppose any attempt by defendants or the intervenors to be relieved from this Order.

[6] Since this case involves overcrowding in the prisons, inspections of those conditions by plaintiffs and their medical and correctional experts is critical to the fact-finding process. In the fall of last year, both plaintiffs and defendants conducted such inspections. Defendants' position now is that further inspections are "irrelevant." Plaintiffs believe that their previous inspections are adequate, provided that defendants are not permitted to introduce evidence of conditions occurring after the last inspection or argue that plaintiffs' evidence does not reflect current conditions.

F. Defendants' Request for a Dispositive Motion Schedule

Plaintiffs are not aware of any testimony by their experts that overcrowding is not the primary cause of defendants' inability to provide constitutionally adequate medical and mental healthcare or that relief other than a prisoner release order will remedy the constitutional violations. In light of the significant dispute between the parties about these issues, plaintiffs suggest a preliminary order from the Court requiring defendants to provide more detail as to which experts made these statements, when they were made, and what the statements were. In the absence of a *prima facie* showing that there is not a significant dispute about the facts, the Court should not entertain a summary judgment motion.

IV. DEFENDANT-INTERVENORS' PROPOSAL

The Legislator, Law Enforcement, County, Sonoma County, and District Attorney Defendant-Intervenors propose the following schedule:

June 30, 2008	Discovery reopens
August 15, 2008	Last day to complete written discovery and non-expert depositions.
August 15, 2008	Expert disclosures due.
August 22, 2008	Last day to disclose rebuttal experts.
September 5, 2008	Last day to complete expert discovery.
September 17, 2008	Last day to file dispositive motions.
September 29, 2008	Last day to file oppositions to dispositive motions.

* * *

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
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Defendants.

ORDER FOR PRETRIAL PREPARATION

The Court has carefully considered the pretrial dates and issues discussed by the parties and intervenors in their June 9, 2008 written statement and at the June 27, 2008 status conference. With good cause appearing, the Court orders as follows:

1. Dispositive motion schedule:

a. In their June 9, 2008 statement, Defendants contended that a dispositive motion schedule would be appropriate based on testimony by Plaintiffs' experts that overcrowding was not the primary cause of the constitutional violations at issue and that a prisoner release order was not the only means of remedying the constitutional violations. At the June 27, 2008 status conference, Defendants further represented that they could file a [2] statement detailing such testimony in short order. Accordingly, on or before *July 10, 2008*, Defendants shall file with the Court a list of the specific testimony by Plaintiffs' experts that Defendants contend eliminates any issue of material disputed facts in these proceedings. No responses to Defendants' filing shall be required nor accepted unless otherwise ordered by this Court. The Court will review Defendants' filing to determine whether a summary judgment schedule would be appropriate and will issue an appropriate scheduling order as necessary.

b. Defendants and Defendant-Intervenors represented to the Court at the June 27, 2008 status conference that they may seek to file a motion to dissolve the proceedings before this Court based on changed circumstances. Any such motions shall be filed within fourteen calendar days after the close of the current state legislative session, or by *September 8, 2008*, whichever is later. Oppositions to such motions shall be filed no later than twenty-one calendar days after the motion is filed, and replies shall be filed no later than twenty-eight calendar days after the motion is filed. No oral argument will be heard unless otherwise ordered by the Court.

2. Discovery:

a. As ordered at the June 27, 2008 status conference, the magistrate judge's October 30, 2007 order requiring discovery responses within twenty-one calendar days of service shall remain in full effect.

b. On or before *August 1, 2008*, the parties and intervenors shall disclose lists of all non-expert witnesses whom they intend to call to testify at trial.[1] Absent a showing of very good cause, depositions of non-testifying witnesses shall be prohibited, as will trial testimony by any witnesses who are not timely disclosed. Motions to depose a non-testifying witness shall be brought before the magistrate judge. Motions to allow a non-disclosed witness to testify at trial shall be brought before this Court.

[3] c. Expert disclosures shall be made, and expert reports exchanged, on or before *August 15, 2008*.

d. Rebuttal expert disclosures shall be made, and rebuttal expert reports exchanged, on or before *August 27, 2008*.

e. Additional site inspections of prison facilities may be conducted through and including August 30, 2008. No evidence of changed prison conditions after *August 30, 2008*, shall be admitted at trial. This prohibition does not include evidence of legislative changes that may occur after August 30, 2008.

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[1] These disclosures need not include witnesses who may only be called for impeachment or rebuttal.

f. Non-expert discovery shall be completed on or before *September 8, 2008*.

g. Expert discovery shall be completed on or before *October 6, 2008*.

3. Motions in limine: Any motions in limine shall be filed on or before *October 20, 2008*. Oppositions shall be filed on or before *October 30, 2008*. No oral argument will be heard unless otherwise ordered by the Court.

4. Other pretrial filings: On or before *October 30, 2008*, the parties and intervenors shall file a joint pretrial conference statement, all expert reports, and all trial declarations of percipient witnesses.

5. Pretrial conference: The Court will conduct a pretrial conference on *Monday, November 10, 2008, at 1:30 PM*, in Courtroom Number 12 of the United States District Court for the Northern District of California, located at 450 Golden Gate Avenue, San Francisco, California. Pursuant to 28 U.S.C. § 2284(b)(3), Judge Henderson may conduct the pretrial conference individually, although Judges Reinhardt and Karlton may also choose to participate.

6. Trial:

a. As ordered at the June 27, 2008 status conference, the Court's October 10, 2007 order regarding direct testimony shall remain in effect. Thus, "[d]irect testimony from all percipient witnesses will be presented by affidavit and no more than fifteen minutes of live testimony, followed by cross-examination. Direct testimony from [4] expert witnesses will be presented through their expert reports and no more than thirty minutes of live testimony, followed by cross-examination." Oct. 10, 2007 Order at 6. As the

Court explained at the status conference, its allowing time to present live testimony on direct is not intended to encourage the parties or intervenors to do so.

b. Trial will begin on *November 18, 2008, at 1:30 PM*. Trial shall run on Tuesdays from 1:30 PM to 4:00 PM, and on Wednesdays through Fridays from 9:15 AM to 4:00 PM.[2] There will be no trial on Mondays, or on November 25 through November 28. Trial shall be held in the Ceremonial Courtroom for the United States District Court for the Northern District of California, located at 450 Golden Gate Avenue, San Francisco, California.

c. Whether trial should be bifurcated remains under submission. Trial will not be bifurcated unless otherwise ordered by the Court.

d. Intervenors are reminded of this Court's February 8, 2008 order that "[a]t trial, one attorney may question each witness on behalf of all intervenors. The same attorney need not question all witnesses. Intervenors will, however, present their evidence and question other parties' witnesses through not more than a total of three different attorneys throughout the trial." Feb. 8, 2008 Order at 2.

IT IS SO ORDERED.

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[2] The Court may revisit the daily trial schedule as the trial date nears. It will provide the parties and intervenors with as much notice as possible if there are any scheduling changes.

Dated: 07/02/08

/s/
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

[5] Dated: 07/02/08

/s/ Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR UNITED STATE DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: 07/02/08

/s/ Thelton E. Henderson
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

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ORDER RE: DEFENDANT'S REQUEST FOR EVIDENCE FROM THE CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION

On August 29, 2008, Defendants filed a request for this Court to permit Defendants to obtain "updated, authenticated, and admissible factual evidence regarding the delivery of medical care at CDCR [California Department of Corrections and Rehabilitation] institutions for use at trial." Req. at 3. In particular, Defendants "seek all reports, memoranda, and any other documents providing factual data and/or current information regarding the following":

1. The status of the URS/Bovis 10,000 bed project, including accomplishments, timelines, and goals, as of August 30, 2008.
2. The status of the information technology system, including timelines, capabilities, and goals, as of August 30, 2008.
3. [2] The status of the Clinical Data Repository/Clinical Portal project, including accomplishments and timelines, as of August 30, 2008.
4. Staffing and staffing vacancies for medical positions both statewide and at each CDCR institution as of August 30, 2008, including but not limited to, registered nursing positions, physician and surgeon positions, physician assistant positions, Chief Medical Officer positions, Chief Physician and Surgeon positions, and licensed vocational nursing positions.
5. Current statistics regarding the number of physicians who were fired and/or retired due to actions taken by the Receiver in accordance with the State Personnel Board.
6. Current status of the Receiver's physician clinical competency policies and implementation plan, including timelines for completion and goals.

7. Current status of any and all training and supervision plans for any and all medical staff positions, including but not limited to, registered nurses, physicians and surgeons, physician assistants, Chief Medical Officers, Chief Physicians and Surgeons, and licensed vocational nurses.
8. Current status of the Receiver's Career Executive Assignment program, including number of positions created and filled.
9. Current statistics regarding the number of preventable and/or possibly preventable deaths statewide, as of August 30, 2008.
10. The status of each institution's adoption of the Emergency Medical Response System policy.
11. The status of implementation of a central fill pharmacy.
12. The status of implementation of a standardized health records practice.
13. The status of the Receiver's efforts to improve radiology and laboratory services.
14. The status of the Receiver's "Construction Upgrade Program."
15. The status of the Receiver's plans to improve the screening of incoming prisoners at all reception centers, including the status of the San Quentin pilot program and plans for a statewide roll-out.

Id. at 6-7.

[3] Part of the rationale for Defendants' request is that this Court ordered that "[n]o evidence of

changed prison conditions after August 30, 2008, shall be admitted at trial," July 2, 2008 Order for Pretrial Prep. at 3, but that the Receiver's next quarterly report is not due to be filed until September 15, 2008. Defendants argue that without the information they request, they will be prejudiced because they will be forced to rely at trial on the Receiver's previous quarterly report, filed on June 17, 2008, instead of being permitted to introduce evidence of prison conditions as of the Court-ordered August 30, 2008 deadline.

The Court agrees that the Receiver has made progress between the date of the last quarterly report and August 30, 2008, and that evidence of such progress may be relevant to the issues to be presented at trial. However, the Court has consulted with the Receiver and determined that it would be unduly burdensome on the Receiver to produce both his next quarterly report and information on the above items as of August 30, 2008. The Receiver has further informed the Court that the September 15, 2008 quarterly report will cover all of the fifteen items included in Defendants' request for evidence.

Accordingly, with good cause appearing, IT IS HEREBY ORDERED that the Receiver's September 15, 2008 quarterly report shall be admissible at trial as to the fifteen items identified in Defendants' request for evidence. To be clear, the Court will permit a limited exception to the August 30, 2008 cut-off for evidence of changed prison conditions and, subject to the Federal Rules of Evidence, will allow the Receiver's September 15, 2008 quarterly report, and any exhibits thereto, to be admitted into evidence at trial as to the fifteen items listed above. Consequently, the Defendants' request for information is DENIED as moot.

IT IS SO ORDERED.

Dated: 09/05/08

/s/
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

[4] Dated: 09/05/08

/s/ Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR UNITED STATE DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: 09/05/08

/s/ Thelton E. Henderson
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

Achieving a
Constitutional Level of Medical Care
in
California's Prisons

Ninth Quarterly Report of the Federal Receiver's Turnaround Plan of Action

September 15, 2008

[1] Section 1

Introduction and Executive Summary

During the June 15, 2008 through September 15, 2008 reporting period, significant progress continued toward attaining the Receiver's vision of providing "constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain." Furthermore, the Receiver's programs were implemented in a cost effective manner. For example, the Maxor program projects a pharmacy cost avoidance savings to California taxpayers of approximately $33 million in 2008. More important than improvements in staffing, fiscal saving, organization, public health programs, infrastructure, and access to care, however, is the fact that the Receiver's efforts have reduced prisoner mortality rates. Simply stated, the Turnaround Plan of Action has begun to have an impact exactly where intended, improving medical care for those prisoners most at risk.

This is the first Quarterly Report that incorporates the metrics developed to measure Turnaround Plan of Action progress. Over time, the metrics provided in this report will improve in terms of both quantity and quality as new measurement systems are implemented and necessary information technology systems are established in California's prisons. To assist the reader, this report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific Turnaround Plan of Action objectives are set forth in this report with the narrative discussion of the objective. Note that some objectives (e.g., the reception center element of the access to care clinical initiative) are in a development stage, and therefore it is premature to implement metrics. However, other programs (e.g., the hiring of clinical personnel) can be measured by very specific metrics.

2. *Appendices*: In addition to providing metrics, the report also references a number of documents, which are provided to the reader in the attached Appendices filed concurrently with this report.

3. *Web Site References*: Concerning two large documents referenced in the report, the McKenzie Stephenson Report regarding Diagnostic Imaging and the Navigant Report regarding Laboratory Services, an executive summary only is provided as an appendix. The entire report, however, is available on the Receiver's website. Likewise, a third large document, the Corrections Corporation of America healthcare related Corrective Action Plan for its facility at Tallahatchie, Mississippi, is also available on the Receiver's website.

> A chart summarizing the status of each of the six goals of the Turnaround Plan of Action is provided below. Objectives and actions' status shaded green are currently on schedule to be completed by the specified finish date. Objectives and actions' status shaded yellow are currently delayed slightly from the specified finish date. Objectives [2] and actions' status shaded red are currently delayed from the specified finish date. Discussion and explanations regarding delays are included in Section 3 under the respective objective and/or actions. Objectives and actions which have been accomplished are noted with a "check box."

* * * *

[9] approval. This action item is moving forward consistent with the scheduled time frames set forth in the Turnaround Plan of Action.

> *Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons*

Following the anticipated approval of the new statewide policy in January 2009, the Reception Center Core Team will initiate implementation at all other reception centers statewide, scheduled for completion by January 2010. This action is on schedule to complete the projected statewide implementation by January 2010.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on health care access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution

Preliminary Operational Assessments

This action is ahead of schedule. Preliminary Operational Assessments have been completed at 32 California Department of Corrections and Rehabilitation (CDCR) institutions. Specifically, in this reporting period, the final three Preliminary Operational Assessments were completed at Calipatria State Prison, California Correctional Institution, and Chuckwalla Valley State Prison. The final three assessments resulted in the recommendation of 207.26 correctional officer positions for use as clinic officers, escort officers and transportation officers. An additional 38.54 supervisory/management positions were also recommended to provide the appropriate level of supervision.

During this reporting period, the Special Master in *Madrid* completed oversight of Pelican Bay State Prison. Pursuant to a Court-approved stipulation by the parties in *Madrid*, Pelican Bay State Prison is now within the purview of the *Plata* litigation and under the authority of the Receivership. This change will necessitate an additional prison Preliminary Operational Assessment, which is scheduled for January 2009.

Operational Re-Assessments

As reported in past Quarterly Reports, the initial eight Preliminary Operational Assessments lacked the scope and depth of review that prisons have received at the later reviews. In order to ensure the same methodology and analysis is utilized in all the Preliminary Operational Assessments, it has been determined that additional assessments of the initial eight institutions, excluding Avenal State Prison and Correctional Training Facility, Soledad, will be conducted. During this reporting period, Sierra Conservation Center was re-assessed. By December 31, 2008, the following six re-assessments are to be completed: Wasco State Prison, Ironwood State [10] Prison, High Desert State Prison, California Conservation Center, California State Prison-Solano and Richard J. Donovan Correctional Facility.

To summarize, all Operational Assessments will be completed on schedule by January 2009.

Action 1.2.2 By July 2011, the Receiver will have fully implemented Health Care Access Units and developed health care access processes at all CDCR institutions

The Health Care Access Units at the California Medical Facility and San Quentin State Prison continue to operate effectively and efficiently and are fully supported by the prisons administrative, clinical, and custody staff Both San Quentin State Prison and the California Medical Facility continue to report a reduction in missed appointments and an increase in inmate access to health care. During July 2008, efforts were initiated to establish a Health Care Access Unit at the Correctional Training Facility, Soledad. Upon conclusion of the detailed analysis of custody health care operations inclusive of the planned construction of new clinical space, the recommendation is for 67 posts or 108.26 new positions. Of the positions, 48.72 positions or 50.42% are allocated for Hospital Guarding and 20.06 positions or 20.76% are allocated for Transportation. Activation of the Health Care Access Unit at Correctional Training Facility, Soledad is scheduled for completion by November 1, 2008.

As discussed in the last Quarterly Report the Receiver approved 134.2 new positions for the activation of the Health Care Access Unit at Avenal State Prison, scheduled to activate July 1, 2008. The Health Care Access Unit at Avenal State Prison was activated on August 11, 2Q08. Custody Support staff will continue to monitor the progress of the Avenal State Prison Health Care Access Unit and remedy issues as they arise.

This action items remains on schedule. Health Care Access Units will be established at California Institution for Men, California Rehabilitation Center, California Institution for Women, and Mule Creek State Prison by June 30, 2009. This action item is also on schedule to complete implementation of Access Units statewide by July 2011.

Monthly Health Care Access Quality Report – Data Collection Instrument

The purpose of the Access Team concept is to ensure prisoner access to medical, mental health, and dental care in a timely and cost-effective manner. To verify this result, an audit instrument was developed during the previous reporting period to formally measure access team performance. Pilot measurement programs to implement the instrument, the

"Monthly Health Care Access Quality Report" were established at San Quentin State Prison, California Medical Facility, California State Prison-Corcoran and Avenal State Prison as of July 1, 2008. All prisons were to implement the instrument developed by the pilot as of October 1, 2008, following training that should have been provided on August 7, 2008. Because of the State budget crisis, however, travel for CDCR staff was suspended and the training did not take place. Training is now scheduled for September 24-25 2008, subject to passage of a State budget. The new implementation date is November 1, 2008. A draft version of the Monthly Health Care Access Quality Report is attached as Appendix 3.

* * * *

[25] Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1. Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

Action 3.1.1. By January 2009, fill 90% of nursing positions

Recruitment efforts continued to focus on physicians and nurses during the reporting period. The results have been very positive. As of July 30, 2008, approximately 88 percent of nursing positions are filled (this percentage is an average of all six State nursing classifications) which is within 2 percent of the statewide goal of having 90 percent of nursing positions filled.

Furthermore, the goal of filling 90 percent of the Registered Nurse (RN) positions has been achieved at 22 institutions (67 percent of all prisons), and 10 prisons have filled 95 percent or more of their RN positions. Ten more institutions (30 percent) have filled 80 to 89 percent of their RN positions. The goal of filling 90 percent of the Licensed Vocational Nurse (LVN) positions has been achieved at seventeen institutions (52 percent); nine of these institutions have filled 90 percent or more of their LVN positions. Seven institutions (21 percent) have filled 80 to 89 percent of their LVN positions. Ten institutions (30 percent) have achieved the goal of filling 90 percent of their Psychiatric Technician (Psych Tech) positions, and four of these ten institutions have 95 percent or more of their Psych Tech positions. Thirteen institutions have filled 80 to 89 percent of their Psych Tech positions.

The following hiring related initiatives continue during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2) presentations at nursing schools statewide; (3) advertisements in local papers, professional trade magazines, and online; and (4) mass mailers target LVN classifications. A mailer is planned for Psych Techs during the next quarter. Additionally, there continues to be a push at all institutions with nursing vacancies to schedule interviews on a weekly basis and interview all interested applicants expeditiously.

Action 3.1.1 is on schedule to achieve the 90 percent fill rate for nursing positions by January 2009.

For additional details related to vacancies and retention, refer to the Plata Vacancy and Retention Report for June 2008. This report is attached as Appendix 6.

The following metrics are included: Table 2 summarizes nursing filled percentages by prison;

Table 3 summarizes nursing turnover rates by prison (refer to Objective 3.3 for explanation); and Table 4 summarizes nursing filled percentages and turnover rates by prison.

* * * *

[29] *Action 3.1.2. By January 2009, fill 90% of physician positions*

Physician recruitment efforts focused on "hard-to-fill" institutions during the reporting period. This focus is appropriate because most urban institutions have now hired their full component of primary care providers. These focused efforts have proven successful. For example, Avenal State Prison, which historically has had difficulty staffing their physician positions, recently hired four physicians. Correctional Training Facility and Salinas Valley State Prison, both with a long-term history of serious hiring problems, have collectively hired ten physicians since the centralized hiring process began. Pelican Bay State Prison, which also experienced serious shortages of primary care providers until recently, is now fully staffed with physicians and mid-level providers.

As of July 30, 2008, approximately 85 percent of physician positions are filled (this percentage is an average of all three State physician classifications). This is within 5 percent of the statewide goal of having 90 percent of physician positions filled. One hundred percent of the Chief Medical Officer positions are filled; 85 percent of the Chief Physician and Surgeon positions are filled; and 82 percent of the Physician and Surgeon (P&S) positions are filled. Thirteen institutions (39 percent) have achieved the goal of filling 90 percent of their P&S positions and twelve of these institutions have filled at least 95 percent of their P&S positions. Seven institutions (21 percent) have filled 80 — 89 percent of their P&S positions. With the exception of San Quentin State Prison, all institutions still proving to be "hard-to-fill" are located in the Central Valley region.

Specialized recruitment efforts for physicians continue with advertisements placed in professional periodicals, newspapers, online, direct mailers, conferences, and visits to residency programs. In addition, efforts are underway to contract with a search firm that can assist in finding candidates for the hard-to-hire locations.

Action 3.1.2 is on schedule to achieve the 90 percent fill rate for physician positions by January 2009.

For additional details related to vacancies and retention, refer to the Plata Vacancy and Retention Report for June 2008. This report is attached as Appendix 6.

The following metrics are included: Table 5 summarizes physician filled percentages by prison; Table 6 summarizes physician turnover rates by prison (refer to Objective 3.3 for explanation); and Table 7 summarizes physician filled percentages and turnover rates by prison.

* * * *

[80] Section 8
Conclusion

As the Court forecast in its Order Appointing New Receiver, filed January 23, 2008, the Receivership has now decidedly entered "an implementation phase, during which the Receivership must translate the conceptualized reforms into reality" (Order

Appointing New Receiver at p. 4). In order to understand and organize the complex reforms which are necessary, the Receiver worked with stakeholders and the Courts to produce the Turnaround Plan of Action which now guides all of our initiatives. With the Turnaround Plan of Action in place and a strong focus on project management, concrete, measurable progress is now plainly evident. We know where we need to go, and we are aggressively moving in that direction. The Receiver's message of planning, project management and progress is paying off.

The steady reduction in the prison population's death rate per 100,000 is one of the strongest indicators of our progress. We are confident that this reduction is largely attributable to the Receiver's efforts over the last 30 months. For the first time in many, many years, there is genuine reason for some hope that CDCR's health care system can be fixed, and that the Receiver is the right instrument for completing the fix in a reasonable period of time and at reasonable cost.

The most serious obstacle to continued progress is the State's failure to provide funding for the Receiver's facilities improvement and expansion program. The progress which has been made to date will be for naught unless we are able to make permanent improvements to CDCR's facilities. Right now, the facilities are simply inadequate, given CDCR's population, to sustain for the long-term the improvements we are seeing. The Turnaround Plan of Action recognized that a long-term solution requires improvements at each adult institution and construction of new facilities to care for CDCR's most seriously and chronically ill patient-inmates. The Receiver fervently hopes the State will, even at this late date in the budget process, recognize its federal constitutional obligations and provide the necessary funding for the Receiver to move forward with his construction program.

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

NO. 2:90-cv-00520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NO. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

DEFENDANTS' MOTION IN LIMINE NO. 15 REGARDING DEFINITION OF THE STATUTORY PHRASE "THE PRIMARY CAUSE"

To: Three-Judge Panel

[2] TO PLAINTIFFS MARCIANO PLATA AND RALPH COLEMAN AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that Defendants Arnold Schwarzenegger, et al., will move the Three-Judge Panel for an in limine order to define the statutory phrase "the primary cause," as it is used in § 3626(a)(3)(E)(i) of the Prison Litigation Reform Act. Defendants request that the Three-Judge Panel define "the primary cause" as "the chief or principal cause," and the cause that is "highest in importance." This motion is based on this notice, the points and authorities below, the Court's file in this case, and any further argument presented to the Three-Judge Panel.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

A prisoner release order is an extreme remedy that should not issue unless it will cure the constitutional violation in question and the violation cannot be fixed any other way. Here, the alleged constitutional violations at issue are the delivery of medical and mental health care in California's prisons, not overcrowding, housing, or other environmental conditions affecting the general population. Defendants are not deliberately indifferent to the medical and mental health needs of Plata and Coleman class-members, and overcrowding is not the "primary cause" of those alleged constitutional violations. Therefore, a prisoner release order is not the proper remedy.

Defendants move in limine for an order defining the statutory term "the primary cause," as that term is used in the Prison Litigation Reform Act, 18 U.S.C. § 3626(a)(3)(E)(i). Specifically, Defendants request that the Three-Judge Panel rule that the phrase "the primary cause" means "the chief or principal" cause, and the cause that is "highest in importance."

II. ARGUMENT

In order for a three-judge court to enter a prisoner release order, it must find by clear and convincing evidence that "crowding is the primary cause of the violation of a Federal right" and that "no other relief will remedy the violation of the Federal right." 18 [3] U.S.C. § 3626(a)(3)(E)(i). The statute does not define the phrase "the primary cause." Moreover, there is no precedent defining this phrase. Accordingly, the Three-Judge Panel must look to the ordinary meaning of these terms. *See United States v. Jackson*, 480 F.3d 1014, 1022 (9th Cir. 2007) ("When statutes use common words without explicitly defining them, we look to dictionaries to understand the statute's meaning.").

The word "primary" means "first in rank or importance; chief; principal." *Webster's Third New International Dictionary* 1800 (2002). Another dictionary defines "primary" as "first or highest in rank, quality, or importance; principal." *American Heritage College Dictionary* 1106 (4th ed. 2002). In turn, "cause" means "something that occasions or effects a result." *Webster's Third New International Dictionary* 356 (2002). Further, the statute's use of the word "the," which the dictionary defines as "so as to exceed all others," emphasizes that crowding has to be the main cause, rather than one of the causes of the violation of a Federal right. *Id.* at 2369. "In construing statute, definite article 'the' particularizes the subject which it precedes and is word of limitation as opposed to indefinite or generalizing force 'a' or 'an.'" *In re Dow Corning Corp.*, 237 B.R. 380, 404 (Bankr. E.D. Mich. 1999) (quoting *Black's Law Dictionary* 1477 (6th ed. 1990)). Thus, the phrase "the primary cause" means "the chief or principal cause," as distinguished from *one* of the main causes, or simply a cause. Accordingly, in order to enter a prisoner release order, the Three-Judge Panel must first find by clear and convincing evidence that crowding is "the chief or principal" cause or "the highest in importance" causal factor of the violation of a Federal right, rather than merely one of the causes of such violation.

The legislative history of the PLRA supports this reading of the statute. The House Report discussion states that "By requiring that a plaintiff prove an actual violation of his constitutional rights based on the *alleged overcrowding*, this subsection will end the current practice of imposing prison caps when inmates in local prisons have complained about the prison conditions but the presiding judge has made absolutely no finding of unconstitutionality or even held any trial on the allegations." H.R. Rep. No. [4] 104-21, at 25 (1995) (emphasis added). The Senate made it similarly clear that the purpose of the PLRA was to "establish[] tough new conditions that a Federal court must meet before issuing a prison cap order." 145 Cong. Rec. S14414 (daily ed. Sept. 27, 1995) (statement of Sen. Dole). In this way, the Senate hoped to curtail what it called "Perhaps the most pernicious form of judicial micromanagement." (*Id.*) Thus, the plain meaning of the phrase "the primary cause" is consistent with the legislative intent of the PLRA, which was to make prisoner release orders "the remedy of last resort." H.R. Rep. No. 104-21, at 25 (1995).

III. CONCLUSION

For the foregoing reasons, Defendants respectfully request that the Three-Judge Panel rule in limine that the phrase "the primary cause" under the PLRA means "the chief or principal" cause, and the cause that is "highest in importance."

DATED: October 20, 2008

/s/ Paul Mello
PAUL MELLO
Attorneys for Defendants
Arnold Schwarzenegger, et al.

DATED: October 20, 2008

EDMUND G. BROWN JR.
Attorney General of the State of California

/s/ Kyle A. Lewis
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[1] UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. 2:90-cv-00520 LKK JFM P
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Defendants.

TRIAL AFFIDAVIT OF TODD JERUE
To: Three-Judge Panel

---

[2] I, Todd Jerue, declare:

1. I am a Program Budget Manager in the Department of Finance for the State of California. I have personal knowledge of the facts stated in this declaration and if called to testify about those facts could and would do so competently.

I. *Current Position and Background*

2. I assumed my current position as a Program Budget Manager in the Department of Finance (DOF) in June 2006. As a Program Budget Manager, I have responsibility for overseeing the preparation and submission of the annual operations and support budget of approximately 50 State agencies and departments, including the California Department of Corrections and Rehabilitation (CDCR). Roughly 25-50% of my time is spent overseeing budget matters for CDCR. I supervise two assistant managers, six supervisors, and approximately 12 staff, plus clerical personnel. I report directly to the Chief Operating Officer of DOF and ultimately the Director of Finance.

3. Before my appointment as a Program Budget Manager, I served in a number of budget analyst positions at DOF. From October 2004 until my current appointment in June 2006, I served as an Assistant Program Budget Manager at DOF overseeing budget matters for CDCR, the Department of Justice, and various other departments. From July 2002 to October 2004, I was a Principal Program Budget Analyst on the CDCR assignment and was responsible for examining and developing correctional operations budget issues. Prior to that assignment, I was a Principal Program Budget Analyst on the Department of Justice/Judiciary assignment from July 2001 to July 2002. From August 2000 to July

2001, I was a Principal Program Budget Analyst at DOF assigned to work on general government budget matters. From 1997 to 2000, I was an Assistant Finance Budget Analyst and Staff Finance Budget Analyst at DOF working on budget matters for a variety of State departments. I was awarded a Masters of Business Administration from California State University, Sacramento in 1994 [3] and obtained a Bachelor's Degree of Science in Business Administration from that institution in 1990.

II. *Overview*

4. A significant portion of CDCR's annual support and operations budget is devoted to the provision of health care services, including medical care, mental health care, and the custody, control, and transportation of inmates to health care appointments. Over the past two decades, and in particular in the last three years, the amount of budget expenditures directed toward the provision of CDCR health care services, including medical and mental health care services, has increased dramatically. As discussed in greater detail below, since Fiscal Year (FY) 1994-95 the annual CDCR budget expenditures for health care services has increased more than 550% to its current level in FY 2007-08. In the same period, the in-state inmate population in CDCR-operated prisons has increased less than 30%. As a result of the increased funding versus population growth during this time, CDCR has allocated significantly more funding to service the health care needs of its inmate population, resulting in demonstrably higher per inmate costs. Additionally, I anticipate the Medical program operated by the Receiver will continue to request budget augmentations to support CDCR health care operations.

III. *Progression of Health Care Services Program Funding Within CDCR*

5. The amount of funds appropriated to CDCR for the operation of its inmate health care services program has steadily grown over the past years. The information contained below, while general in nature and reflecting in-state CDCR population figures and budgets that are fluid, is nonetheless indicative of a greatly increased allocation of funding to CDCR for the provision of inmate health care services.

6, During Fiscal Year (FY) 1994-95, a total of $344 million was expended for CDCR health care services, including mental health and medical care services. Due to changes in categorization of budget expenditures, I am not able to determine if this total [4] includes expenditures for health care administration costs and/or custody-related costs, or how much was spent on those items during that period. Taken on the whole, nonetheless, the average daily inmate population at in-state CDCR-operated prisons as of June 30, 1995 was 126,758, resulting in a per inmate expenditure of approximately $2,714.

7. During FY 2005-2006, a total of $1.252 billion was expended for CDCR health care services, including mental health and medical care services, health care administration, and the custody, control, and transportation of inmates to health care appointments. The average daily inmate population at in-state CDCR-operated prisons as of June 30, 2006, was 164,712, resulting in a per inmate expenditure of approximately $7,601.

8. During FY 2006-2007, a total of $1.635 billion was expended for CDCR health care services, including mental health and medical care services,

health care administration, and the custody, control, and transportation of inmates to health care appointments. The average daily inmate population at in-state CDCR-operated prisons as of June 30, 2007, was 167,532, resulting in a per inmate expenditure of approximately $9,759.

9. During FY 2007-2008, a total of $2.249 billion was expended for CDCR health care services, including mental health and medical care services, health care administration, and the custody, control, and transportation of inmates to health care appointments. This represents a 554% increase in expenditures for CDCR mental health and medical care services as compared to FY 1994-95, and an 80% increase in overall CDCR health care services program expenditures from just two years earlier in FY 2005-06. The average daily inmate population at in-state CDCR-operated prisons as of June 30, 2008, was 163,231, resulting in a per inmate expenditure of approximately $13,778. This is a 408% increase in per inmate expenditure from FY 1994-95, and an 81% increase in per inmate expenditure from FY 2005-06.

[5] 10. In FY 2008-2009, the anticipated expenditure for CDCR health care services, including mental health and medical care services, health care administration, and the custody, control, and transportation of inmates to health care appointments is $2.193 billion. This decrease in anticipated expenditures is due to the removal of the unallocated Program 97 funds from the CDCR health care services program budget, in addition to the projected reduction of the CDCR prison population and resultant cost reduction. The average daily inmate population at in-state CDCR-operated prisons, based on the 2008 May Revision of the Governor's Budget projection, is

157,992, resulting in a per inmate expenditure of approximately $13,887.

IV. *Conclusion*

11. Based on the foregoing budget expenditure statistics, the amount of funding appropriated to and utilized by CDCR for health care services programs in the past 14 years has dramatically increased, including a sizeable increase in expenditures since just FY 2005-06. Furthermore, in comparison to the average in-state CDCR inmate population, health care service expenditures have far outpaced the growth of the CDCR inmate population. As a result, there has been a concomitant increase in the expenditures for CDCR health care services on a per inmate basis, particularly in recent years.

I declare under penalty of perjury that the foregoing is true and correct. Executed in Sacramento, California on October 30, 2008.

/s/ TODD JERUE
TODD JERUE

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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NOTICE

The following documents have been omitted from the printing of this Deferred Joint Appendix. They may be found in the Appellants' Appendix to the 09-416 Jurisdictional Statement at the following pages:

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and in the Appellants' Appendix to the 09-1233 Jurisdictional Statement at the following pages:

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[1] UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF CALIFORNIA AND THE
NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

Case No. CIV S-90-cv-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Case No.: C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TRIAL DECLARATION OF STATE ASSEMBLYMEMBER TODD SPITZER

[2] I, Todd Spitzer, testify as follows:

1. I am a State Assemblyman representing the 71st Assembly District, which comprises eastern Orange County and western Riverside County. I have served as a State Assemblyman for three consecutive terms, since 2002. I make this declaration based on my personal knowledge. If called to testify as to the contents of this declaration, I could and would competently do so.

2. I testify in my capacity as an individual intervenor, and my testimony represents my own views and beliefs.

3. Prior to my time in office as an assemblyman, I served as a Deputy District Attorney in Orange County from 1990 to 1996.... Also during that period, I graduated from the Los Angeles Police Academy and became a Reserve Police Officer. I served as a Reserve Police Officer in Los Angeles for ten years....

4. As an Assemblyman, I currently serve as the Chairman of the Select Committee on Prison Construction and Operation, and on the Health and Human Services, Revenue and Taxation and Joint Legislative Audit Committees.

* * *

9. A prisoner release order that involves early release or a prison cap not only jeopardizes public safety, it is premature and unnecessary, as less intrusive alternatives to a prisoner release order are available.

[3] 10. One alternative to a prisoner release order is the full and complete implementation of Assembly Bill 900 ("AB 900"), which was signed into law on May 3, 2007. AB 900, a bipartisan bill, authorized

funding to build thousands of prison, beds, strengthen inmate health care delivery, and improve rehabilitation programs in state prisons, and county jails. Before a prisoner release order is considered, the Court should give the California Department of Corrections and Rehabilitation ("CDCR") enough time to implement the construction and improvements authorized by AB 900.

* * *

12. AB900 authorized funding to build thousands of prison beds to ease the overcrowding crisis in our prisons. I witnessed the extent of this overcrowding crisis firsthand in March of 2007, when I toured eight California state prisons, including one while in the presence of Governor Arnold Schwarzenegger, The housing of inmates in gyms, dayrooms, and other spaces intended for programming is completely unacceptable. Housing inmates in this manner precludes the CDCR from fulfilling the crucial need to rehabilitate inmates. When fully implemented, AB 900 will remedy the overcrowding crisis in California prisons by removing these "bad beds" in gyms and day rooms that take up valuable programming space. Freeing up this programming space will enable CDCR to [4] conduct the rehabilitative programming necessary that is essential to lower crime rates and to protect the public's safety.

13. AB 900 is a comprehensive plan, and in addition to funding bed construction, it also authorizes funding for vocational and education programs, substance abuse treatment programs, and other rehabilitative programming that will curb California's rampant recidivism rate. California has a 70% recidivism rate, which means that 70% of released offenders go on to commit new crimes. Providing

sufficient space and resources to conduct rehabilitative programming in state prisons and county jails is essential to lower California's recidivism rate and ensure public safety.

14. Another crucial aspect of AB900 is the construction of reentry facilities that will house offenders in the last eighteen months of their incarceration. Reentry facilities will allow offenders serving the last portion of their sentences to be housed closer to their communities to facilitate their reintegration into society. These state-run facilities will provide county-based services to rehabilitate offenders who are currently churning in and out of the prison system without undergoing any rehabilitative programming. Equipped with these services and programs, released offenders will be less likely to commit new crimes.

15. AB 900 also allocated funding for construction that will provide thousands of medical, mental, and dental health care, which will address the underlying constitutional concerns in the *Plata* and *Coleman* actions.

16. Thus, AB 900 is a less intrusive means to correct any violations of constitutionally adequate medical and mental health care. AB 900 is in and of itself sufficient to alleviate overcrowding, without resorting to an extreme remedy such as a prison cap or early release order. The provisions of AB 900 and CDCR's implementation of AB 900, will eliminate bad beds in the prisons and provide for reentry facilities; both of these measures will enhance rehabilitative programming within the prisons and consequently, public safety. Finally, AB 900 provides funding for the Receiver's construction plans, thereby strengthening medical and mental health care delivery.

17. Together with my colleagues in the Senate and Assembly, I have repeatedly called for the removal of all roadblocks that are precluding us from fully executing the provisions of AB 900. Attached hereto as Exhibit B is a true and correct copy of an article entitled "A Look at AB 900 One [5] Year Later. . . . Nothing," that I authored with my colleague, Senator George Runner, which was published in the online Flash Report on July 24, 2008.

* * *

20. The overcrowding in California's prisons interferes with rehabilitation and, more specifically, vocational, educational, and substance abuse programming. The effects of overcrowding on rehabilitative programming must be distinguished from any effects of overcrowding on health care delivery.

21. Consistent with statements made by the Receiver appointed by Judge Henderson in *plata v. Schwarzenegger*, Clark Kelso, I believe that overcrowding is not the primary cause of any constitutional inadequacies in the delivery of medical or mental health care. Rather, issues such as funding and staffing are the primary hindrances to CDCR's provision of health care.

22. A second less intrusive means of remedying any shortcomings in the provision of constitutional medical and mental health care in the state prisons is permitting the Receiver to continue and complete the work he is doing in improving the health care system in CDCR institutions.

23. The Court's orders equipping the Receiver to upgrade CDCR's health care delivery system have not yet failed. Indeed, Mr. Kelso only assumed the position of Receiver earlier this year, on January

23, 2008. Accordingly, a prisoner release order is premature.

[6] 24. Attached hereto as Exhibit C is a true and correct copy of a May 22. 2008 letter from Judge Henderson to Senator Mike Machado.

25. In the letter, Judge Henderson states that the Receiver's program "represents an appropriate, cost-effective plan that will address the major treatment and housing concerns in all four federal class actions," referring to the *Plata*, *Coleman*, *Perez*, and *Armstrong* actions. Exhibit C at 2. It is the Receiver's efforts, rather than an early release order or prison cap, that are the most effective way to address the underlying issue in these law suits—health care delivery in CDCR institutions.

26. On August 13, 2008, I attended a press briefing at the Sacramento Press Club featuring *Plata* Receiver Clark Kelso. Attached hereto as Exhibit D is a true and correct copy of a DVD of an August 13,2008 press briefing held by Clark Kelso at the Sacramento Press Club.

27. Consistent with Mr. Kelso's statements during that briefing. CDCR's provision of health care delivery does not primarily hinge on population level. Consequently, the size of the population is not the primary factor in the CDCR's ability to ensure health care delivery.

28. During that briefing, Mr. Kelso, stated, in response to a question regarding the effects of overcrowding on health care provision, "I'm just not seeing difficulty in providing medical services no matter what the population is." Exhibit D at 30:00 minutes. Thus, according to the Receiver, the Receivership can provide constitutional healthcare in CDCR institu-

tions, regardless of the size of the inmate population. *Id.*. As Mr Kelso continued, "its a question of how much you're willing to spend for it." *Id.* Mr. Kelso also stated, "I think we've discovered that you actually can provide care and certainly our plan and turnaround plan—we believe we can provide constitutional levels of care no matter what the population is." *Id.* at 31:20 minutes.

29. If adequate health care can be provided at any population level, then resorting to extreme measures such as a population cap or prison release order is wholly inappropriate. Alternative and less intrusive means, such as allowing the Receiver to continue his work, which includes construction of beds and hiring more health care staff, are better suited to addressing the underlying violations at issue in *Coleman* and *Plata.* In fact, the Receivership has been allocated approximately 51.8 billion in the State's 2008-2009 budget, of a total of $2.3 billion allocated to prison health care, to continue that progress.

[7] 30. Not only would a prisoner release order he a premature response that does not remedy the underlying issues in the *Plata* and *Coleman* actions, the public safety consequences of a prisoner release order would be dire.

33. The inmates who would be released early have not had the opportunity to spend time in reentry facilities or rehabilitative programming, because AB 900 has not been carried out as promised, and because of overcrowding. Thus, there is a high likelihood that they will reenter their communities and commit new crimes.

* * *

I declare under penalty of perjury under the laws of the State of California and the United States that the foregoing is true and correct and that this declaration was executed by me this 30th day of October 2008.

By: Todd Spitzer
Todd Spitzer

EXCERPT OF TRANSCRIPT OF VIDEO RECORDING (*Plata* D.E. 1656, Ex. D)

TITLE: Sacramento Press Club,
Speaker: J. Clark Kelso

DATE: August 13, 2008

SPEAKER	*TEXT*
Moderator	* * * Well, today's guest's already made some news a couple of hours before this event so I think we're going to hear a little bit more about that from him when he comes up. That news, of course, has to do with his current duties. He's no stranger to state government and, I think, has probably earned the reputation as the consummate fix-it man on a number of policy issues. Of course, his reputation really began in the Summer of 2000 when he served a stint as the state insurance commissioner in the wake of the resignation of Commissioner Chuck Quackenbush and all the allegations surrounding that and in 2002 stepped in after another scandal at the state's department of information technology and ultimately became the state's chief information officer working to turn around the state's troubled information technology program. Of course, as you know, that's not the end of the story. In January, U.S. District Judge Thelton Henderson appointed our guest to be the receiver overseeing

improvements to the healthcare offered in California prisons which, of course, is the subject of legal action and a tug of war over monies and priorities with a lot of state officials, most notably, the Governor. In fact, you may remember that the former Prison Healthcare Receiver, Bob Sillen was our guest here last July. I should also mention that today's guest continues to serve as a professor of law and director of the Capital Center for Government Law and Policy at the McGeorge School of Law and with that it's my honor to welcome to the Sacramento Press Club, Clark Kelso.

* * *

Kelso What I want to talk about very briefly is simply my experience in, you know, as the Mr. Fix-It. What do you do when you've got a troubled agency or a troubled department. How do you turn things around?

* * *

In the receivership one of the big challenges they had when I showed up, they had not clearly identified what their job was and that made it difficult for them to plan and I think we have at this point clearly identified what our job is, what our challenge is. Our job is to as soon as practicable, provide constitutionally adequate medical care to patient-inmates of the CDCR in a delivery system the state can successfully manage and sustain. That's our job and it is to turn it back over to the state.

* * *

I want to try and identify the challenge, the next step is to identify for the organization a shared mission, very similar to identifying the challenge but you have to get your people agreeing on a mission. In our case, in the receivership it is fairly straightforward. We want to reduce avoidable illness and death by providing patient inmates timely access to safe, effective and efficient medical care. That's it, that's all it's about really, and actually if I define the mission that way as we have, then we start to know what to measure, avoidable illness and avoidable death, and we actually spend the significant resources on looking at every single death that occurs within CDCR and doing a comprehensive review from a medical perspective to determine whether it was an avoidable death. We get reports on those on a monthly basis. Once you've got the challenge identified on the shared mission, a leader needs to enable action particularly in a large organization you don't do things by yourself. A lot of other people have to be empowered to act and you have to let them act.

* * *

The administration and the legislature have been extremely cooperative in providing the receivership with the resources it needs and basically they have funded all aspects of my strategic turnaround plan with one exception. Now the one exception does happen to be a large one, but I frankly am very pleased at where the receivership finds itself. We are getting the support of the Governor's office and the legislature to get us the people, the medical support and information systems that we need, support for procurement activities; it's really quite remarkable the degree of support that we are getting and we will resolve the issue about the facilities I'm sure in the next couple of weeks.

* * *

Sigrid Bob: I teach at Sac[ramento] State and I have covered prisons and health care issues for many years for several publications starting at the [Sacramento] Bee in the 70's. You mentioned investigations or reports on avoidable deaths, could you elaborate on that, give us some examples or if you see a pattern?

Kelso

* * *

[W]e see recently, for example, a death of someone who essentially had a heart attack, where the conditions should have been diagnosed and treated rather easily. And instead what happened was, well, there had been multiple interactions and they sent the person back to their cell without any treatment. So you see quite a range of things, often times, what we see are lapses because of bad coordination between nurses, doctors, lab results, external experts. We don't yet have very good information systems that make it easy to share information. So a lot of what we see are failures in communication, failures in handoff from one practitioner to another, but the reports I get are quite detailed.

***

Jim Lindburg, Friends Committee on Legislation: Thank you. It's been suggested pretty strongly by a lot of people in this arena that the reason that the prison system can't deliver constitutionally adequate health care is because of the huge growth in the prison population and that it is not just a matter of beds and facilities but also being able to deliver services. Like I understand in a lot of rural counties, it is very hard to get doctors and clinical personnel, and I'm just wondering if you, as the receiver, do you have an official position on what we should do about the prison population?

Kelso: Let me comment at least a little bit about that. We're not having that much difficulty in recruiting clinical personnel anywhere in the state. It turns out when you raise compensation to private sector levels, people will come. So we are not having difficulty recruiting nurses and doctors. With doctors, we're close to 90% statewide. Now we're having a little difficulty with doctors in the desert portion of the state. They don't like living in the desert, so we are having to figure out some creative solutions for staffing there. Nurses interestingly enough, we are able to recruit nurses up and down the state, even in the desert. For nurses, the place where we have a challenge recruiting is on the coastal areas. Large urban costal. We've got a little bit of a challenge there. I suspect because the standard of living, the expenses of living in the coastal are a little higher. So, I'm just not seeing difficulty in providing medical services no matter what the population is. It is a question of how much are you willing to spend for it. Now, the overcrowding, without a doubt the overcrowding creates additional not just expenses but complications in providing medical services because frankly everything in the prisons is made more difficult by overcrowding. They can't provide any sort of program, for example, in many prisons; they just don't have any room to provide any sort of programs. So everybody is sitting around. Well, that by itself creates a health care problem. If you've ever walked up and down the gymnasiums where their bunks are three high, I have absolutely no doubt that the conditions of overcrowding by itself contributes to greater morbidity. It's like birds on a wire who are crammed too close together. It creates additional stress. I'm confident that is happening. Is it happening to any huge and great extent that we can't respond to? I'm less sure about that. I think we have discovered that you actually can provide care, and it is certainly our plan, our turnaround plan, we believe we can provide constitutional levels of care no matter what the population is.

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TRIAL DECLARATION OF STATE SENATOR GEORGE RUNNER

[2] I, George Runner, testify as follows:

1. I have been a Senator for the State of California representing the 17th Senate District since 2004. The 17th District incorporates portions of the Los Angeles, San Bernardino, Ventura and Kern counties. I began my career in politics running for city council in the City of Lancaster in 1992 and subsequently served as Mayor. In 1996, I was elected to the State Legislature in the Assembly. I served three terms as a State Assemblyman until 2002. This declaration is based on my personal knowledge, and I am prepared to further testify as to its contents.

2. I am testifying in my capacity as an individual intervenor and my testimony represents my own views and beliefs.

3. As a Senator, I co-authored, along with San Bernardino County Supervisor Gary Ovitt, the Safe Neighborhoods Act, which is Proposition 6 on the November 2008 ballot. I drafted Proposition 6 after undergoing thorough discussions with law enforcement groups, victims' advocates and policy experts from all over the State about a measure that would benefit and sustain programs to deter and suppress gang activity and violence in California communities. Proposition 6 is a comprehensive anti-gang and crime reduction measure that will bring more cops and increased safety to our streets and greater efficiency and accountability to public safety programs and agencies that spend taxpayer money.

* * *

[3] 8. Overcrowding in prisons interferes with programming and rehabilitation. However, overcrowding does not prevent the provision of constitutionally adequate health and mental care. California

can and does provide adequate care given current resources. I believe that court-appointed *Plata* Receiver Clark Kelso has provided a constitutionally adequate level of inmate health care this year

9. California's extraordinarily high recidivism rate is largely the cause of current crowding conditions. California is the only state in the nation that sends more offenders to prisons from parole than from court. The high recidivism rate is, in large part, a product of California's move from indeterminate to determinate sentencing in the late 1970's. Under indeterminate sentencing, an inmate was released from prison only upon establishing to the satisfaction of a parole board that he had rehabilitated and was no longer a threat to the public. The burden was on the inmate to successfully complete vocational training or education programs and/ or to establish that he had a job, a place to live, and a plan to success upon release. Under the current determinate sentencing system, an inmate is released when his days served and his accumulation of early release credits equal his sentence. Inmates serving determinate sentences are released, ready or not, without regard to whether they have a plan, a job, or a home, or have succeeded in any prison programs. For many, responsibility and incentives have been eliminated from the system. I believe that more facilities to educate and rehabilitate inmates in carefully monitored programs will lower recidivism as will focused parolee monitoring programs. Moreover, I believe that many non-violent parole violators can serve periods of [4] revocation on GPS-monitored house arrest. In 2006, Governor Schwarzenegger and the State Legislature facilitated a new emphasis on inmate rehabilitation and reintegration hack into the community, as evidenced by the passage of Assembly Bill 900. These efforts to

help offenders help themselves will result in lower recidivism rates and, consequently, greater public safety as a result of fewer crimes committed but will take time to produce results.

10. Health care costs per inmate (over $12,000 per inmate per year) in California are among the highest in the United States. In fact, prisoners have greater access to medical and mental health care than the average Californian. As I understand it, the California Department of Corrections and Rehabilitation's health care expenditures have increased significantly in the past 8 years from just under $700 million in 2000, to approximately $2.4 billion in 2007. This information is illustrated in Exhibit C, attached hereto, which is a true and correct copy of a graph entitled "CDCR Healthcare Budget, 2000-2008," My staff compiled the data for this graph in July of 2008 from publicly available state statistics.

11. California's prison population has grown at approximately half the pace of California's overall population over the past decade. I understand that California's inmate population has increased by only 8% between 1998 and 2008, whereas California's general population has increased by 16 °A in that same timeframe. Also, during this time, California's total inmate population has grown an average of less than 1% per year, slower than the composite inmate population growth rate for the other 49 states and considerably slower than California's overall population growth. Accordingly, California has a lower prison incarceration rate in 2008 than it did in 1998. Furthermore, I understand that since January 1, 2008. Texas, with 13 million fewer people, had more prison inmates than California. Therefore any public perception that California has had disproportionate

growth in rates of incarceration over the past 10 years is mistaken.

12. Attached hereto as Exhibit D is a true and correct copy of a document entitled California Prisons 1998-2008: Prison Inmate Population has Become More Violent." My staff compiled the data for and drafted this report in July, 2008. This report is based in part on the Pew Center on the States report, "One in 100: Behind Bars in America 2008," published in February of 2008. Exhibit D illustrates the data discussed in paragraph 11 above.

[5] 13. As I understand it, the average annual mortality rate for US residents ages 15-64 was 308 per 100,000 residents from 2001-2003. The average annual mortality rate for state prisoners in all states is 250 per 100,000 prisoners from 2001-2006, whereas California's rate was 213 per 100,000 prisoners during the same time period. These figures indicate that California has one of the lowest prisoner mortality rates within, the United States. At the same time, California's inmates are among the oldest in the country. This information evidences the provision of constitutional health care.

14. This data is confirmed in Exhibit E, attached hereto, which is a true and correct copy of a document entitled "National and State Prisoner Mortality Rates (California Inmate Mortality – 38th Lowest Among States)." My staff compiled this data and drafted this memorandum in July of 2008 using data from the Bureau of Justice Statistics, Data Brief: Medical Causes of Death in State Prisons, 2001-2004 (Appendix Table ii), January 2007, and Bureau of Justice Statistics, Death in Custody Statistical Tables: State Prison Deaths, 2001-2006, June 2008.

15. A prisoner release order is not necessary for the provision of constitutionally adequate health and mental care in California prisons. Moreover, other viable alternatives exist to solve the issue of overcrowding in California prisoners.

* * *

[6] 20. Finally, the *Plata* Receiver must have more time to implement his Turnaround Plan of Action which Judge Henderson approved on June 16, 2008. In fact, the current *Plata* Receiver was appointed only earlier this year, on January 23, 2008. As I understand it, the death rate of California prisoners first increased but then dropped almost 30% since the beginning of 2006, when inmate healthcare was seized from state control by the Receiver. This drop is due to the Receivership's success in reducing the number of preventable deaths in state prisons due to inadequate access to care. As an alternative to a prisoner release order, this Court should allow the Receiver to continue the work he is doing in improving the delivery of health care in CDCR institutions.

* * *

22. There is no question that early release endangers public safety. For example, early release of prisoners in Los Angeles County jails has led to tragic and dangerous consequences. Since 2002, when Los Angeles County jails closed their doors to prisoners due to budget shortages, nearly 16,000 inmates were rearrested and charged with new crimes while they were supposed to be in jail. Sixteen of those inmates were charged with murder; a quarter were charged with violent or life-endangering crimes, including robberies, sex offenses,

weapons violations, drunk driving incidents, assaults and kidnappings.

* * *

[7] I declare under penalty of perjury under the laws of the State of California and the United States that the foregoing is true and correct and that this declaration was executed by me this 30th day of October, 2008,

By: /s/ George Runner
George Runner

REPORT OF JAMES AUSTIN, PHD

Coleman v. Schwarzenegger et al.,
No. Civ. S-90-0520 LKK

Plata v. Schwarzenegger et al.,
No. CO1-1351 T.E.H.

AUGUST, 2008

[1] 1. In this report, I demonstrate that California can reduce its prison population without adversely impacting public safety.

2. Reducing the prison population will require one or two events to occur – a lowering in the number of people being admitted to prison and/or a reduction in the amount of time to serve (also known as length of stay or LOS). As I explain below, given California's unique prison population, it is possible to divert some people who otherwise would have been incarcerated, and to shorten some sentences, without adversely impacting public safety.

Basis for My Opinion

3. In addition to the matters set forth in my November, 2007 report, I have been asked to render my opinion on whether a "prisoner release order" as defined by the Prison Litigation Reform Act would have an adverse impact on public safety or the operation of a criminal justice system.

4. The opinions set forth in this declaration are based on my extensive experience studying and researching correction systems, including my recent work on the CDCR Expert Panel on Adult Offender and Recidivism Reduction Programming (hereinafter, "Expert Panel") on my review of data and documents provided to me by plaintiffs' counsel and counsel for CDCR and the intervenors and on my visits to Cali-

fornia State prisons, including, most recently, my expert tour at CSP-Lancaster on November 2. 2007.

5. In preparation for this report. I have reviewed the same documents that I reviewed in preparing for my November, 2007 report. I also reviewed additional documents, listed in Appendix A to this Report. This report is also based on documents [2] and data that I received while working on the Expert Panel, including current population trend data.

6. I have neither authored any publications nor testified as an expert witness in court since my report of November, 2007. My curriculum vitae and the rate that 1 am charging plaintiffs for my work on this case has remained the same.

Background to Overcrowding in California's Prisons

7. There is no question that California's prison system is severely overcrowded. As shown in Table I, the current CDCR institutional population is now at 156,003 male and female prisoners. The CDCR design capacity is only 79,828 indicating a crowding ratio of 197%. The situation would be even more severe if one were to include the 4,400 California prisoners temporarily being housed in out of state private prison systems (Mississippi, Arizona, Oklahoma and Tennessee). Crowding in California's prisons has been a constant condition for many years. Nearly two decades ago in 1990. California's prison population was only 86,942 but the design capacity was 47,221 or a crowding ratio of 184%.

8. In 2006 the US Department of justice reported that California's prisons were more overcrowded than any other states.[1]

9. A major factor contributing to California's crowding problem is that California has one of the highest recidivism rates in the country when one uses the measure of being returned to prison within three years. According to the Virginia [3] Sentencing Commission, only Kansas, Utah and Alaska have higher return to prison recidivism rates than California.[2]

10. This was not always the case. In the 1970s California's recidivism rates were much lower. Figure 1 shows how the California return to prison recidivism rate accelerated very rapidly over a relatively short period of time and reached a peak in the late 1980s. It has since slowly declined but remains twice the level it was in the 1970s.

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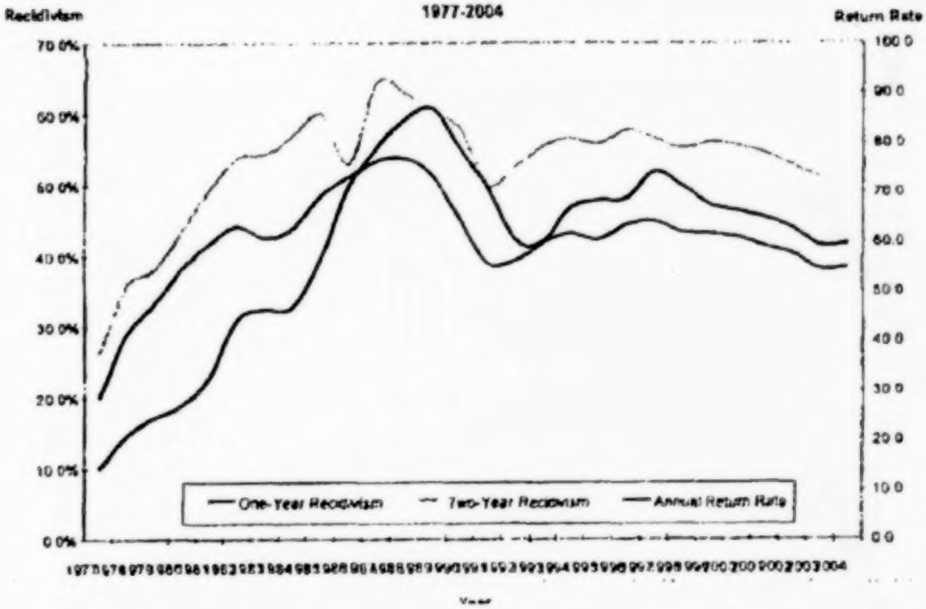
[1] William Sabol, Heather Couture, and Harrison Page. December 2007. *Prisoners in 2006*. Washington. DC: Bureau of justice Statistics, US Department of Justice.

[2] Based on information compiled by Rick Kern, Ph.D.. Director, Virginia Criminal Sentencing Commission from various state department of corrections and sent to me on August 14, 2008.

[4] Figure 1: California's Historical One & Two Year Return to Prison Recidivism Rate with Annual Return to Prison Rate[3]



[5] 11. California's return to prison recidivism rate is so high that the US Department of Justice noted that when deleting California from its analysis of national trends, the overall national return to prison recidivism rate drops from 52% to 40%.[4]

12. As will be shown later, over 91,000 admissions to prison in California are parole violators, of which approximately 69,000 are for technical parole violations. Technical parole violators are individuals

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[3] This chart is a reproduction of Figure E-1 from Joint Pls. "1r. Ex. 2, Expert Panel on Adult Offender and Recidivism Reduction Programming. 2007, "A Roadmap for Effective Offender Programming in California," ("Expert Panel Report") Appendix E at 88.

[4] Patrick Langan and David J. Levin. June 2002. Recidivism of Prisoners Released in 1994. Washington, DC: Bureau ofiustice Statistics, US Department ofJustic.T, p. 8. Table 9.

returned to prison for a violation of their parole supervision conditions, and not for conviction of a crime. While some of these individuals were arrested for criminal activity, they have not been convicted of a new crime. Because the rate of technical parole violations in California is so high, more than I out of every 3 parole violations in the nation occurs in California. And when California is deleted from the national data, the percentage of prison admissions that are parole violators for the nation drops from one third to one quarter.[5]

13. The explanation for this trend is that California imprisons more parole violators (not that parolees in California commit more crimes). A recent study of California*s recidivism rates concluded that the three year re-arrest rate is similar to many other states. it is the high use of imprisonment for parole violations that produces the high return to prison rate.[6] Moreover, the Sabol and Couture study, a report by Dr. Joan Petersilia and another report by Blumstein and Beck[7] all conclude that California's [6] unique system of imprisoning technical parole violators actually worsens public safety because it

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[5] William J, Sabol and Heather Couture, June 2008. *Prison Inmates at Midyear 2007*. p. 19. Washington, DC: Bureau of Justice Statistics, US Department of Justice.

[6] Ryan Fischer, "Are California's Recidivism Rates *Really* the Highest in the Nation"? It Depends on What Measure of Recidivism You use." UCI Center for Evidence-Based Corrections, Irvine, California, Vol. 1, September 2005. Available at http://ucicorrections.seweb.uci.edu/.

[7] Alfred Blumstein and Allen J. Beck, "Reentry as Transient State Between Liberty and Recommitment, in Jeremy Travis and Christy Visher, Eds., *Prisoner Reentry and Crime in America*. Cambridge, Massachusetts: Cambridge University Press, 2005.

disrupts any effort to stabilize both parolees and the communities where they reside.

> "As two leading crime analysts, Alfred Blumstein and Allen Beck, illustrated in a recent study, California's catch and release model of crime control is creating a destructive situation by constantly cycling offenders in and out of prison and their home communities in a way that blurs the distinction between the two and combines the worse elements of each."[8]

14. Another major factor contributing to the increase in California's prison population is the increase in lengths of prison stays for certain types of crimes. The impact of sentencing laws on prison population has been well-documented by the CDCR in its population projection reports and more recently by the Little Hoover Institute.[9]

15. As a result of the high return-to-prison rates and increased sentences, the population of CDCR prisons has steadily increased over the years. However, the most recent report issued this year (CDCR 2008 Spring Adult Population Projection) shows a slight reduction of 3.591 prisoners (or 2%) over the next five years.[10] This slight reduction is the result of lower new court admissions, lower numbers

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[8] Joan Petersilia, May 2006. Understanding California Corrections. Berkley, CA: California Policy Research Center, University of California.

[9] Little Hoover Institute. 2007. "Solving California's Corrections Crisis: Time is Running Out." Appendix F. Sacramento, CA: Little Hoover Institute

[10] California Department of Corrections and Rehabilitation. Spring 2008 Adult Population Projection. (Undated). Sacramento, CA: CDCR.

of parole revocations, and shorter lengths of stay. These factors are the same ones cited by the Expert Panel as possible solutions to the crowding situation. But even the CDCR population projection acknowledges the forecasted population reduction is tenuous, is likely to last only a couple of years, and should not be used for long-term planning purposes (see pages 8 and 9 of the Spring 2008 Adult Population Projection). (Indeed, [7] the methods used by the CDCR to estimate short-term population reductions are being reviewed by two outside experts to determine the validity of the estimating process.) In short, it is uncertain whether the population will actually decline and if it does the amount of the decline and the duration of the decline will be minimal. In any event, even with the projected reduction in population, CDCR's prisons will remain vastly overcrowded.

16. While some degree of overcrowding can be tolerated within a correctional system, there is a point beyond which it becomes very difficult to operate a secure, safe, and humane system for both staff and prisoners. The overcrowding in CDCR now pervades and adversely impacts all aspects of the Operations of the Department, including CDCR's ability to process new prisoners expeditiously. provide adequate medical, mental health and dental care, and provide evidence based programs.[11] The overcrowding also results in inadequate bed space, causing CDCR to take steps such as converting program space to housing.[12] Overcrowding also results in increased violence, resulting in the frequent use of lengthy

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[11] *See, e.g.,* Expert Panel Report at 9-11; Jt Pls. Tr. Ex. 26 (Receiver's Report re Overcrowding); Jt. Pls. Tr. Ex. 1 (Governor's Emergency Proclamation).

[12] *Id.*, Appendix E, at 91.

lockdowns.[13] These responses, which are required to maintain some semblance of order, serve to also exacerbate the difficulty in providing programs and basic medical and mental health services to the prisoner population.[14]

17. There is no reason to believe that the crowding problem will be solved quickly because California has not enacted the systemic reforms necessary to reduce overcrowding.

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[13] *See, e.g.*, Governor's Emergency Proclamation.

[14] *See, e.g.*, Receiver's Report re Overcrowding.

[8] Table 1: Current CDCR Populations and Capacity as of 7/16/08

Population Status	Number
A. Total CDCR Population	171,150
B. Current Institution and Camp Population	160,334
1. Institutions Only	156,003
2. Design Capacity	79,828
3. Percent over design capacity	195%
C. Other Prison Population Demands	
1. Projected 5 Year Reduction – Estimated for institutions @2%	-3,000
2. Current Jail Back Up – Sentenced to CDCR	2,000
3. Prisoners Temporally in Out of State Prisons	4,400
D. Total Additional Institutional Prisoners (Current and Projected) Not in CDCR	3,000
E. Total Institutional Population to Be Accommodated the Next 5 Years (B1±D)	159,003
F. Gap between projected Institutional Population and Design Capacity by 2013 (E-B2)	79,175

http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad080716.pdf

The Relationship between Prison and Public Safety

18. California can reduce its prison population without adversely impacting public safety.

19. A smaller prison population would not, by itself, cause an increase in crime. It is well known that many states with *higher* rates of imprisonment have *higher* crime rates and, conversely, many states with *lower* incarceration rates have *lower* crime rates. But in general, there is no relationship between crime rates and imprisonment rates.[15] And as will be shown below, moderately lowering the prison population and [9] incarceration rate while using evidence-based models for rehabilitation does not result in higher crime.

20. Similarly, large prison populations do not equal less crime. Recent studies based on individual states and counties have estimated the crime-reduction impact of prison growth to be small or non-existent.[16] Research on crime and incarceration does not consistently indicate that the massive use of incarceration has reduced crime rates.

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[15] I conducted an analysis of two US Department of Justice data files containing crime rates and incarceration rates during 2004 by state, and found a correlation coefficient of -.013 which represents no consistent relationship. Looking at violent crime rates only, there is a positive correlation between violent crime rates and incarceration rates, which means that the states with the highest incarceration rates have the violent crime rates.

[16] Bruce Western, *Punishment and Inequality in America*. NY: Russell Sage. 2006), James P. Lynch and William J. Sabol, *Did Getting Tough on Crime Pay?* Crime Policy Report No. 1. Washington, DC: Urban Institute, 1997; Available at www.urban.org/publications/307337.html. Don Stemen *Reconsidering Incarceration: New Directions for Reducing Crime*. New York: Vera Institute of Justice. 2007).

21. Indeed, some research shows that higher rates of imprisonment may actually serve to increase crime rates. This happens in a variety of ways. For example, increasing imprisonment results in the "churning" of large segments of the largely young male population in and out of prison, which serves to disrupt the community and family structure that would otherwise produce low crime rates.[17] Thus, if a state wishes to reduce its crime rate, it will need to look at other factors other than imprisonment. That is, the best way to lower crime rates is *not* to increase imprisonment rates.

22. Moreover, in overcrowded prison systems such as California's, overcrowding has resulted in a reduction in access to basic education, vocational training and drug rehabilitative rehabilitation programs.[18] It is well-known that if prisoners are properly assessed and assigned to well structured programs, persons who complete those programs have lower recidivism rates.[19] Accordingly, overcrowding in California has impeded the [10] State's ability to reduce recidivism. This is why the Expert Panel's first recommendation was to "Reduce overcrowding in its prison facilities

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[17] Dina Rose and Todd Clear, "The Problem with 'Addition by Subtraction': The Prison-Crime Relationship in Low Income Communities," in Marc Mauer and Meda Chesney-Lind, eds., *Invisible Punishment: The Collateral Consequences. of Mass Imprisonment*, NY: The New Press, (2003), pp 181-194; Todd R. Clear, *Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Places Worse*. New York: Oxford University Press. 2007).

[18] *See* Expert Panel Report at 9-11.

[19] *See* Expert Panel Report at 1-2 for a full discussion and referencing of such programs.

and parole office."[20] If the state were able to decrease its prison population, reclaim program space, and reallocate existing resources necessary for effective programming both in the community and in prison, recidivism rates and crime would decline in California.

23. The bulk of the evidence points to three conclusions: 1) The effect of imprisonment on crime rates, if there is one, is small; 2) If there is an effect, it diminishes as prison populations expand (and California's prison population is already greatly expanded); and 3) The overwhelming and undisputed negative side effects of incarceration and crowding far outweigh the potential, unproven benefits of incarceration.

24. According to Professor James Q. Wilson, we have reached a tipping point of "diminishing returns" on our investment in prisons.[21] Wilson reports that judges have always been tough on violent offenders and have incarcerated them for relatively long sentences. However, as states expanded incarceration, they dipped "deeper into the bucket of persons eligible for prison, dredging up offenders with shorter and shorter criminal records."[22] Increasing the proportion of convicted criminals sent to prison, like lengthening time served beyond some point, has produced diminishing marginal returns in crime reductions.

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[20] Expert Panel Report, p. viii.

[21] James Q. Wilson, "Crime and Public Policy" in James Q. Wilson and Joan Petersilia, Crime ICS Press, Oakland, California 1995, page 489-507.

[22] Wilson, op cit., page 501.

[11] 25. Other former incarceration advocates such as Professor Dilulio and former US Attorney General Edward Meese are calling for a repeal of mandatory minimum sentencing and challenging the wisdom of a massive imprisonment policy.[23]

26. The lesson for California is that lowering the rate of imprisonment will have a minimal or even a positive effect on crime rates, and will improve its ability to engage many soon-to-be released prisoners in rehabilitative programming. Specific examples of this phenomenon are presented in the next section.

Prison Population Reduction Measures in Other Jurisdictions

New York

27. New York state offers the most recent and compelling example of how crime and imprisonment rates can be lowered simultaneously. Like most other states, New York began to experience a drop in its crime rate beginning in 1994. The reasons for this drop are the subject of several studies all of which are summarized in Blumstein and Wallman.[24] One common conclusion is that the drop in crime was not precipitated by a surge in imprisonment.

28. The decline in the state's overall prison population was fueled in part by reducing the length of stay for those sentenced to prison. This was achieved by creating programs that allow prisoners to earn

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[23] Jacob Sullum, "Prison Conversion: After Studying Non-Violent Drug Offenders, A Criminologist Who Once Said "Let 'Em Rot" Now Says "Let 'Em Go". Reasonline, http://www.reason.com. August/September 1999.

[24] Blumstein A and Wallman J eds). 2000, The Crime Drop In America. Cambridge University Press, Cambridge, UK.

more "good time" credits and thus become eligible for parole sooner than originally scheduled. A report released by the New York State Department of Corrections, estimates that over 24,000 prisoner were released an estimated six months earlier from 1997 through 2006. Those released earlier had [12] significantly lower recidivism rates and the crime rate in New York also declined substantially.[25]

29. New York City, where much of the State's total drop in crime occurred, was also implementing its now well-known police practices that focused on "quality of life" arrests. As a result, the city experienced a decline in the number of felony arrests while misdemeanor arrests and jail bookings increased. But .because misdemeanants have much shorter lengths of stay in the jail and cannot be sentenced to prison, both the City's jail population and the state prison population declined dramatically.[26] Specifically, the New York City jail population declined from 21,000 to 13,000; the prison population from 71,000 to 63,000 and the probation population from 98,000 to almost 50,000.

30. These reductions in the prison population and rate of imprisonment occurred at the same time as the crime rate was declining. Figures 2 and 3 compare the crime and imprisonment rates for New York with California and Michigan. One could pick any state to compare with New York and it would

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[25] New York Department of Correctional Services. *Merit Time Program Summary, October 1997 December 2007*.Albany, NY: NYDOC.

[26] For a comprehensive assessment of the New York experience see Michael Jacobson, *Downsizing Prisons: flow to Reduce Crime and End Mass Incarceration* (New York: New York University Press, 2005

show the same trend: namely that as New York's rate of imprisonment was declining so too was its crime rates. Other states show the same reduction in crime rates with or without any change in imprisonment rates.

Nevada

31. Nevada has recently enacted reforms that reduced its prison population without impacting. crime rates.[27]

[13] 32. Prior to 2007, Nevada was facing a rapidly expanding prison population fueled in part by an unexpected increase in prison admissions largely form Clark County (Las Vegas). A prison forecast indicated in 2008 that unless steps were taken, the state's prison population would increase from 13,000 prisoners to over 18,000 over the next ten years. Coupled with a worsening economic picture, the state was faced with a growing budget request that would compromise efforts to increase spending on several education and drug prevention initiatives.[28]

33. To address this problem, the state enacted AB 510 in 2007, which increased the amount of "good time" credits a prisoner could earn for good conduct and completion of education and treatment programs.

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[27] I am currently employed by the State of Nevada, the Council of State Governments and the PEW Charitable Trust Foundation to provide consultancy services to the state. I am very familiar with data regarding the state's prison population. For a recent summary of the 2007 Nevada reforms, see the July 7, 2008 powerpoint presentation that I made before the Nevada Advisory Commission on the Administration of Justice, The Council of State Governments, Carson City. Nevada.

[28] *See* CSG Center on Criminal Justice power point dated October 17, 2006

(The law was made retroactive to prisoners who were sentenced in 2000.) The law also provided for probationers and parolees to receive good time credits for satisfactory behavior and compliance with the conditions of probation and parole. The result was that well-behaved prisoners were eligible for parole sooner, and well-behaved parolees were discharged from parole.

34. With the assistance if the U.S. Department of Justice's Bureau of Justice Assistance (BM), the Parole Board also revised its risk based guidelines to better identify low risk candidates for parole for the purpose of expediting their release. The guidelines were designed to increase paroles for prisoners who have completed programs designed to reduce recidivism rates.

Figure 2: New York versus California and Michigan Incarceration Rates: 1996-2006

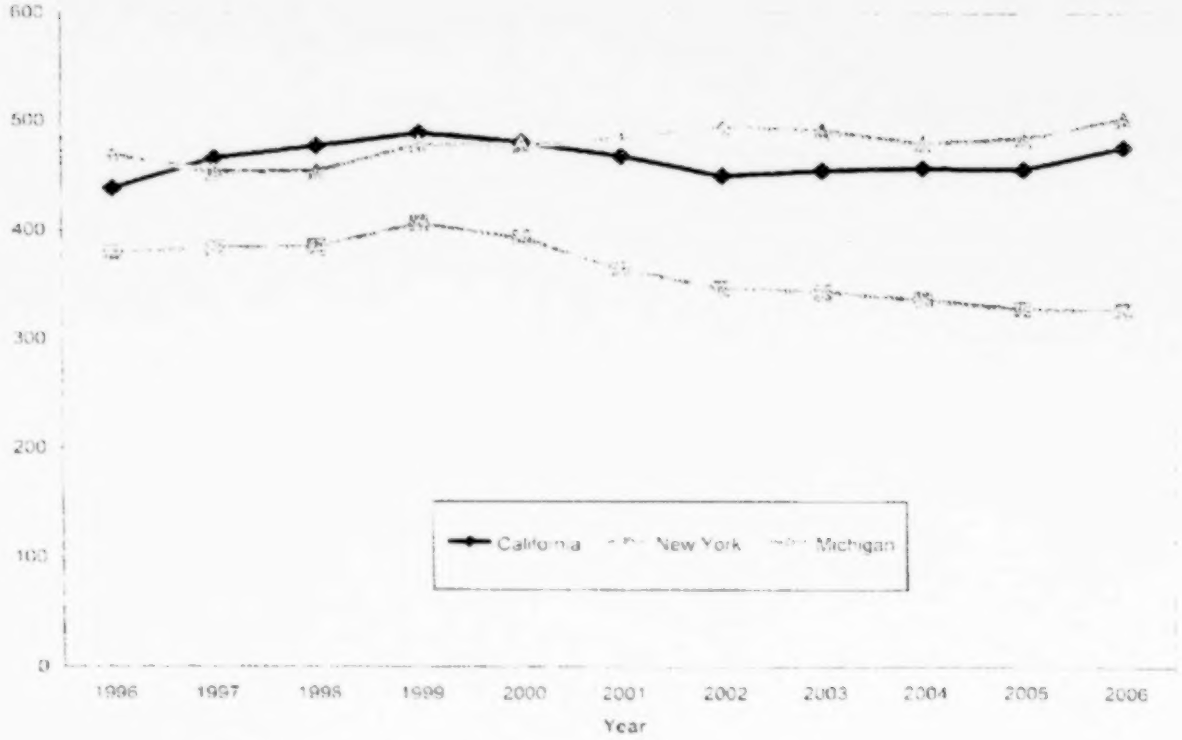
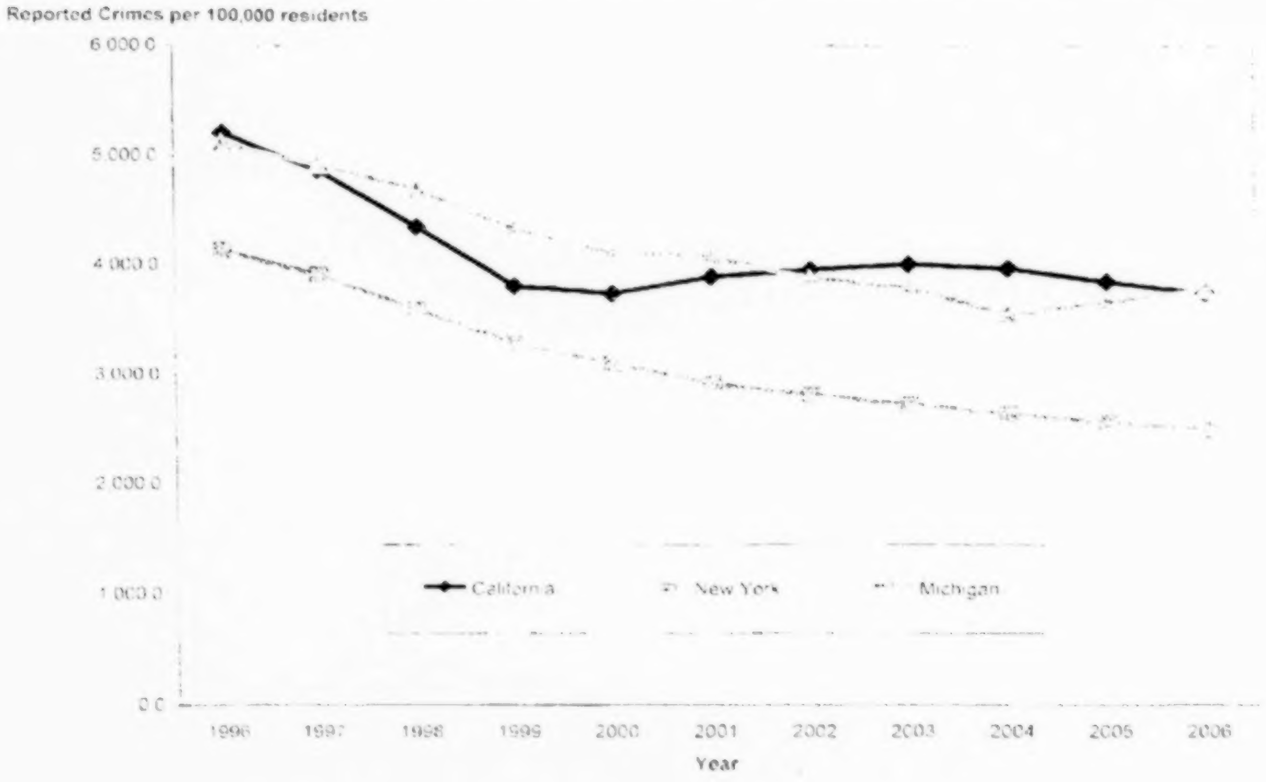


Figure 3: New York versus California and Michigan Reported Crime Indexes: 1996-2006



[16] 35. Finally, the Probation and Parole Division, which supervises all offenders in the community, agreed to develop and implement in coordination with the Parole Board a revocation matrix that would reduce the number of returns to prison for technical violations and the length of stay for technical violations.

36. Since the legislation and new policies took effect in 2007, the prison population reversed its upward arc and has begun a moderate decline (See Figure 4). At the same of time the probation population has declined from 14,400 to 13,500 and the probation violation rate had dropped from 47% to 35%. The state also established an Advisory Commission on the Administration of Justice to monitor reported crime, arrests and court dispositions to see what effect the reforms might have on those key indicators. To date there has been no increases in crime, arrests or court filings.[29]

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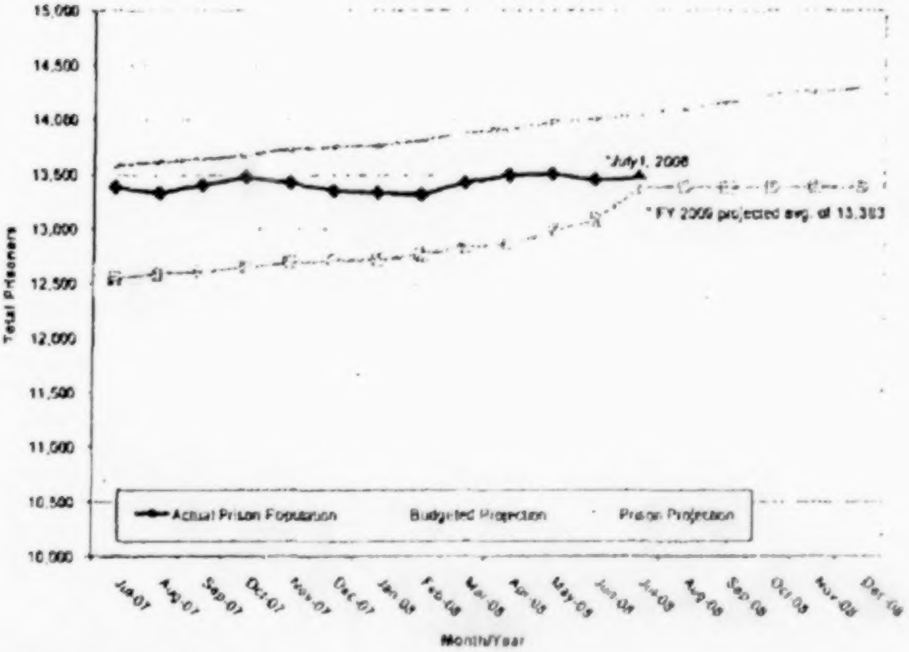
[29] *See* Council of State Governments' power point presentation made to the Nevada Justice Advisory Commission dated July 7, 2008

[17] Figure 4: Projected and Actual Prison Population For Nevada[30]



[18] *Mississippi*

37. Like many states, Mississippi adopted truth-in-sentencing laws in the mid-1990s requiring inmates to serve at least 85% of their sentence before receiving parole consideration. While many states applied this restriction only to violent offenders, Mississippi brought all offenders under the net. As a result, Mississippi's prison population more than doubled over the last 14 years, from 10,500 to 21800. In 1994, the Department of Corrections budget was $109.6 million. This year, it stands at $327 million, and state prisons are at 99% of capacity.

38. This year, with the endorsement of Republican Governor Halley Barbour, Mississippi enacted SB

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[30] The data used to compile this figure was provided to me by the Nevada Department of Corrections.

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2136, a statute that would allow thousands of nonviolent offenders to become eligible for parole after serving 25% of their sentence. Officials say 4,500 inmates, or 24% of the total population, are covered by the new law. I have been retained by the state of Mississippi to conduct population projections to estimate the effect of the new law. Because the measure is retroactive, about 3.000 inmates or about 12% of the total population already have met their time-served requirement and are eligible for immediate parole consideration. The parole board is ramping up to conduct hearings and beginning to process cases. The state is beefing up its parole ranks to prepare for the increased demand for supervision. I estimate that the Mississippi prison population will experience a 20% reduction all based on shorter periods of imprisonment.

California Counties

39. Several California counties have low numbers of persons sentenced to the CDCR without apparent impacts on crime rates.

[19] 40. Table 2 shows the felony prison disposition rates and prison admissions for new convictions in some of the major counties in California. The table demonstrates that there is considerable variation among the counties in both their felony prison disposition rates and prison commitment rates. The statewide felony prison disposition rate in 2005 (the last year reported buy the California Attorney General), is 19%. This number reflects the percentage of felony convictions that resulted in a prison sentence. The most frequent dispositions are probation and probation with a jail sentence (often representing credit for time served in jail awaiting the court's disposition). Riverside, Los Angles and San Bernardino Counties

have felony disposition rates that are significantly higher than the state average. Alameda, Contra Costa, and San Francisco Counties have the lowest felony disposition rates. If Los Angeles, Riverside and San Bernardino alone were to match the 19% statewide felony disposition rate, the number of prison admissions for new convictions would drop by 12% statewide.

41. Similarly, the prison commitment rates per 100.000 population as reported by the CDCR in its annual report vary from a low of 51 and 55 per 100,000 population in Contra Costa and San Francisco, to highs of 314 and 300 for San Bernardino and Kern counties. The variations in prison commitment rates are not explained by variations in crime rates. The prison commitment- crime rate ratio as is shown in the last column of Table 2, and it demonstrates that counties with the higher prison commitment rates do not have the higher crime rates. For example. Los Angeles, Riverside, and San Bernardino have much higher prison commitment rates but their crime rates are similar to Contra Costa, San Diego. and San Francisco, which have much lower prison commitment rates.

[20] 42. This analysis shows that within California, many counties are maintaining low prison commitment rates – meaning that they are keeping offenders in the community – without jeopardizing public safety. What is lacking are statewide initiatives that would help other counties to follow suit.

Table 2: 2005 Felony Court Dispositions and Commitments by County

County	Crime Rate Per 100,000	Prison Disposition Rate	Prison Commitments per Year	Prison Commitments Per 100,000 Population	Prison Commitment to Crime Rate Ratio
Alameda	3,259	9%	1,755	114	.035
Contra Costa	2,876	12%	526	61	.020
Fresno	3,088	16%	2,211	251	.081
Kern	3,135	19%	2,243	300	.096
Los Angeles	2,532	26%	22,003	217	.086
Orange	1,681	18%	4,776	155	.093
Riverside	2,846	26%	5,119	274	.096
Sacramento	3,712	14%	2,180	156	.042
San Bernardino	2,673	21%	6,103	314	.112
San Diego	2,539	14%	4,717	154	.061
San Francisco	2,776	11%	436	55	.020
Santa Clara	1,864	16%	2,388	136	.073
Statewide	2,497	19%	68,356	186	.074

Sources: Crime and Court Disposition rates published by the California Attorney General: Prison Commitments and Rate per 100,000 population published by CDCR in its 2005 Annual Report

Options for California That Will Safely Reduce the Prison Population

43. The size of a prison population is driven by two dynamics admissions and length of stay (LOS). California can reduce prison admissions and reduce length of stay in a safe and practical manner in four ways.: 1) provide evidence-based programming and supervision to technical parole violators instead of returning them to prison; 2) divert low-level offenders to probation and parole instead of prison; 3) provide more avenues for prisoners to earn "good time" credits toward release for good behavior; and 4) provide more avenues for early discharge from parole. Each of these options has been [21] successfully adopted either in California counties or in other states, and has proven to be effective. Further, each of these recommendations were also recommenda-

tions made by the Expert Panel.[31] The recommendations made by the Expert Panel (with one exception) were formally endorsed by the CDCR.[32]

44. It is important to note that individuals who would he diverted or released early under these programs are all people *who would otherwise be returned to the community* within several months of the date that these programs would release them. This report does not contemplate releasing any high-risk offenders or anyone who would otherwise remain incarcerated for life. Thus, the normal risks of recidivism among the population who are released from prison in the ordinary course of events also exists here. As explained below, the actual expected *impact on crime rates* from these population reduction measures is negligible, and implementation of appropriate evidence-based programming can further reduce or eliminate any increase in crime.

Moderately and Selectively Reduce Prison Admissions

45. There are two major types of prison admissions for the CDCR – new court commitments and parole violators. Any moderate reduction in one or both of these two admission streams will have an associated impact on the prison population.

46. As explained above, California has implemented policies that make its prison admission attributes different than any other state in the US. As shown in Table 3, the number of prison admis-

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[31] Expert Panel Report.

[32] *See* letter signed by Secretary James Tilton dated September 25.2007 to the Honorable Denise Ducheny and the Honorable John Laird endorsing all but one of the recommendations of the Expert Panel Report.

sions is extremely lame (because of the large number of technical parole violators being admitted each year), hut the size of the parole technical violator population at any given point is only approximately 20.000 (because the average length [22] of sentence for these admissions is just four months). The difference between California and other major states is shown in Table 4 which further highlights the unique attributes of these California admission numbers.

1. Reducing The Number of Technical Parole Violators

47. California can safely reduce its prison population by reducing the number of technical parole violators who are imprisoned.

48. While California currently incarcerates a high percentage of parole violators, this has not always been the case.

49. Prior to 1976, CDCR had a high parole success rate. 75% of released parolees successfully completed their periods of supervision.[33] In the 1980's however, CDCR and the Board of Prison Terms implemented a number of policies that reduced the parole success rate and increased the number of technical parole violators being admitted to prison.[34] One of the most prominent changes was the decision by the BPT to accommodate local county officials by admitting parole violators who otherwise would have remained in the local jail pending their revocation hearing.

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[33] James Austin, 1987, "Success and Failure on Parole in California, A Preliminary Evaluation", San Francisco, CA: National Council on Crime and Delinquency, Table 3

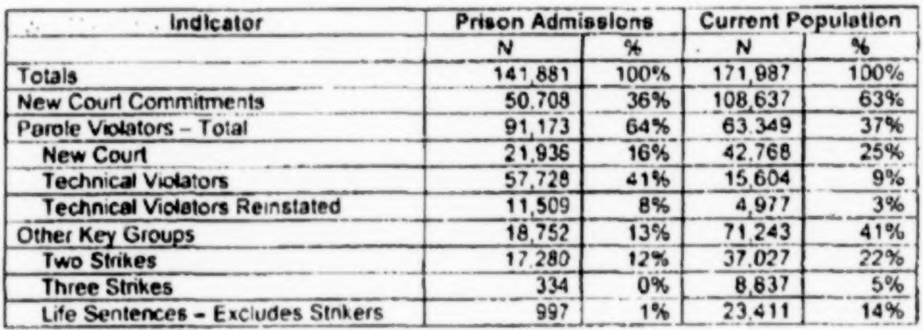
[34] James Austin, 1987, "Success and Failure on Parole in California. A Preliminary Evaluation", San Francisco, CA: National Council on Crime and Delinquency

This was done to help reduce the jail population and jail crowding.[35]

50. Other factors cited by the BPT and CDCR officials that have served to increase parole revocations were 1) a reduction of community treatment resources, 2) increased used of drug testing, 3) decreased ratio or parole agent to parole caseload and [23] 4) the willingness of the prosecutors to accept a parole revocation in lieu of further prosecution.[36]

Table 3

Prison Admissions versus Prison Populations



Indicator	Prison Admissions		Current Population	
	N	%	N	%
Totals	141,881	100%	171,987	100%
New Court Commitments	50.708	36%	108,637	63%
Parole Violators – Total	91,173	64%	63.349	37%
New Court	21,936	16%	42,768	25%
Technical Violators	57,728	41%	15,604	9%
Technical Violators Reinstated	11,509	8%	4,977	3%
Other Key Groups	18,752	13%	71,243	41%
Two Strikes	17.280	12%	37,027	22%
Three Strikes	334	0%	8,837	5%
Life Sentences - Excludes Strikers	997	1%	23,411	14%

Source: CDCR

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[35] *See* report by CDCR official Norm Holt. January 24, 1995. - Reducing Parole Revocations By Improved Decision Making: The California Experience." Unpublished Report. and James Austin, 1987. "Success and Failure on Parole in California, A Preliminary Evaluation", San Francisco, CA: National Council on Crime and Delinquency,

[36] James Austin, 1987. "Success and Failure on Parole in California, A Preliminary Evaluation", San Francisco, CA: National Council on Crime and Delinquency,

Table 4:

Comparisons with Other Major State Prison Systems

Indicator	Michigan	Texas	California	Illinois	New York	USA
2007 Prisoners	50,648	172,626	176,059	45,565	63,536	1,395,916
2006 Incarceration Rate	511	683	475	350	326	445
2006 Crime Rate	3,775	4,598	3,704	3,562	2,488	3,808
Property	3,213	4,082	3,171	3,020	2,053	3,335
Violent	562	516	533	542	435	474
Incarceration/Crime Rate Ratio	0.14	0.15	0.13	0.10	17	0.12
Total Admissions	12,813	42,807	141,881	39,477	26,942	692,303
New Court Commitments	10,714	33,426	50,708	3,825	16,868	441,606
Parole Violators	4,094	9,381	91,173	10,528	9,409	239,495
% Parole Violators	32%	22%	64%	27%	35%	35%

Sources: UCR 2006; BJS 2006; Michigan DOC, Texas DCJ, Illinois DOC, New York DCS

51. There are several methods for reducing the number of technical parole violators. In Washington state, state statutes prohibit parole violators from being re-admitted to prison for a technical violation. Instead, technical parole violators can serve up to 60 days of confinement in the local jail. Other states, including Louisiana and [24] Texas, have restricted how long a person can be re-incarcerated for a technical parole violation.

52. A second method is to use a "violation matrix," a system that evaluates the severity of the violation and the risk-level of the parolee to determine appropriate sanctions for a parole violation. Using a "violation matrix" lowers parole revocations for low risk parolees who are involved in non-criminal conduct. A number of states now use such a matrix including South Carolina, New Jersey, Oregon, Georgia, Iowa, Kansas, South Dakota, and Texas.[37]

53. A third method is to reduce the period of supervision for parolees who comply with their conditions of parole. Such a policy would serve as an incen-

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[37] Personal communication and email from Peggy Burke, Center for Effective Public Policy. August 4-5, 2008.

tive for parolees to behave, and thus reduce violations. As noted above, Nevada has instituted such a law which has reduced the number of both probation and parole violators.

54. Finally, the CDCR could re-institute its own program (successfully implemented in the early 1990s) whereby parole regions would be allocated targets for reducing parole violations which, if achieved would increase community resources for the agents to use. The model consisted of the following live components:

> "1) Broaden the concept of parole to include some accountability for failures,
> 2) Translate operation concepts into budget concepts.
> 3) Redirect part of the avoided prison expenses to parolee support services,
> 4) Train the revocation decision makers and audit decision processes, and
> 5) Keep decision makers regularly informed of the consequences of their actions.[38]

This effort resulted in about 10.000 fewer parole revocations and 3,000 few prison beds being used in 1993.

[25] *Estimated Impact of Reducing Technical Parole Violators*

58. The CDCR Expert Panel estimated that this reform would serve to divert approximately 31,000 of the nearly 70,000 technical parole violations that are

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[38] *See* Holt. "Reducing Parole Revocations By Improved Decision Making: The California Experience," Unpublished Report by CDCR official.

being returned to prison.[39] Given that technical parole violators serve an average of 2-4 months in CDCR prisons, it is estimated that the impact on the projected CDCR institution population would be at least 6,500 or as much as 9,500 at any given time.[40]

56. As important as the bed reduction, the diversion of at least 31,000 technical violators from CDCR prisons would have a pronounced impact on the volume of persons being processed at CDCR's crowded reception centers, and would enable CDCR to improve the level care that it provides at those facilities.

57. If effective evidence-based programming were provided to the technical parole violators, the diversion program would likely have no impact on crime rates. Indeed, for many technical parole violators who are low-risk offenders, the evidence suggests that their recidivism rates would be *higher* if they were incarcerated rather than released to a community setting with appropriate programming.[41]

2. Divert Low Risk Prisoners with Short Sentences

58. CDCR could also moderately reduce prison admissions without jeopardizing public safety by diverting low-risk newly sentenced prisoners who will spend a very short period of incarceration due to their short sentences and credit for jail time (less than 12 months).

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[39] *See* Expert Panel Report at Appendix E. p. 89.

[40] *See* Expert Panel Report. It should be noted that the estimates of the impact of this and other reforms were originally removed from the draft report by the CDCR. They were later reinstated based on the objection of the Expert Panel members.

[41] *See* Expert Panel Report at 23.

[26] 59. As shown in Table 5, there are over 27,000 persons sentenced to the CDCR who were sentenced for a "non-violent" offenses and who do not have a second or third strike against them. A large portion of the population has received a sentence for 16 months.

60. A diversion program would eliminate a short period of imprisonment within the CDCR (during which the prisoner is unlikely to become involved in any meaningful programming), but would not eliminate the period of incarceration in county jails (typically 4-7 months).[42]

Estimated Impact of Diverting Low Risk Prisoners with Short Sentences

61. In analysis completed for me by the CDCR, it was determined that the prison population would be lowered by approximately 16,500 within two years of implementing a diversion program for low-risk offenders.[43] I would lower this estimate by approximately 4,000 to account to other factors that may arise as part of the implementation process (exclusions due to prisoner refusals to participate or designation as a hid risk for release to the community). This would suggest the prison population could be reduced by 12,500 through this reform alone. Moreover, if the state provided appropriate community-based treatment for individuals diverted from prison, the diversion program would likely have a neutral or

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[42] Based on data file forwarded to me by CDCR, Legislative Estimates Unit, Estimates and Statistical Analysis Section, Offender Information Services Branch.

[43] CDCR Critical Statistical Report Request #1, December 2007, Legislative Estimates Unit, Estimates and Statistical Analysis Section. Offender Information Services Branch.

positive impact on public safety. That is because low-risk offenders such as those targeted for such a diversion program have [27] higher recidivism rates when incarcerated and lower recidivism rates when provided appropriate, evidence-based programming in the community.[44]

Table 5

Sentenced for FY2006-2007 Persons Sentenced to 60 months or less Non-Violent, Non-Lifer, Non-Sex Registrant and Non-Strike Crimes/Sentences

Sentence In Months	New Court Prison admissions	% of total Admissions for these crimes
8	131	0%
12	88	0%
16	16,058	42%
18	28	0%
20	10	0%
24	11,450	30%
Sub-Total	27,465	72%
Total	38,393	100%

Source: CDCR PDF file and analysis dated 12/03/07

3. Moderately and Selectively Reduce Length of Stay (LOS)

62. California could also safely reduce its prison population by moderately reducing the length of stay of selected prisoners.

63. One of the most repeated research findings published by the US Department of Justice's Bureau of Justice Statistics (BIS) and various states is that

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[44] Expert Panel Report at 23.

increasing or reducing the period of imprisonment has no associated impact on recidivism rates. The WS reports that the average LOS in the nation's prisons has grown from 20 months in 1994 to 30 months in 2002. This alone accounts for 50% increase in the ADP in the [28] nation's prisons. The BJS recidivism studies and others show no relationship between time served and-recidivism rates.[45]

64. The California CDCR completed an analysis for this author to see if recidivism rates were associated with lengths of imprisonment. Table 6 shows the relationship between how long persons are incarcerated and recidivism rates in California. Although the recidivism rates appear to decline slightly, those declines are not statistically significant except for people who serve more than 24 months, and that reduction in recidivism is due entirely to the maturation of the prisoner (older prisoners have lower recidivism rates). When this study is replicated controlling for age and other related factors, there is no statistically significant difference in. recidivism rates by length of stay. A similar finding was found in the US Department of Justice recidivism studies for 1994 releases of which California participated in and dominates the results by virtue of its large numbers (see Table 7). Moreover, the good time credit programs outlined in this report would only result in a reduction of an average of 4 months of LOS, and nearly all the individuals who would be eligible for such reduction would be serving a sentence of less than 24 months.

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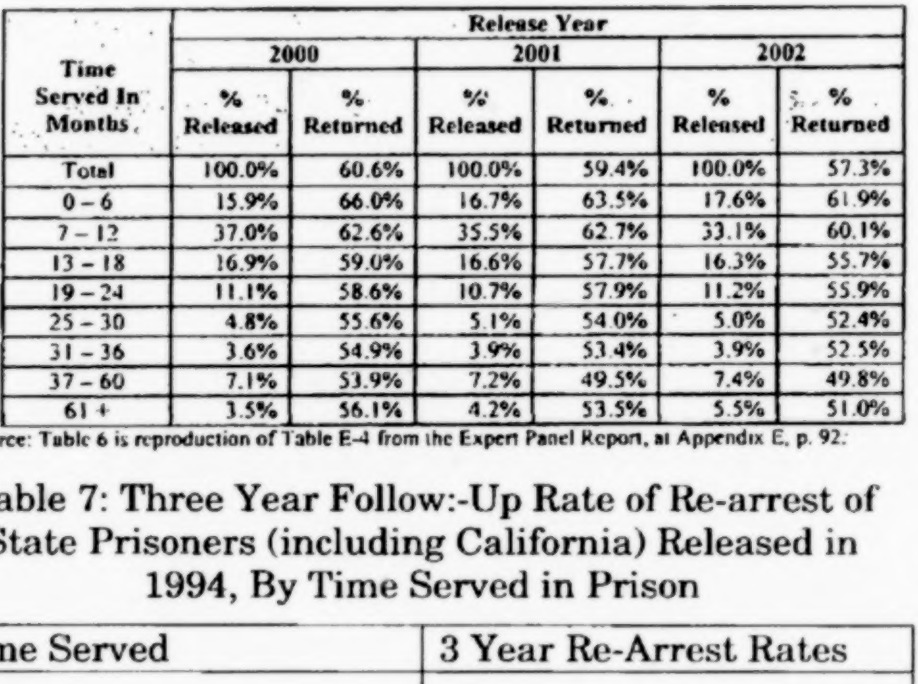
[45] *See* BJS website for analysis of LOS and Recidivism rates at http://www.ojp.usdoj.gov/bjs/correct.htm.

65. It should be noted that even very small changes in LOS can produce very large reductions in a prison population. In California, if all of the 70,000 or so new court commitments spent 30 days less than they do today, the CDCR prisoner population would decline by approximately 5.800 inmates. A three month reduction would drop the population by over 17,000

[29] Table 6: Three Year CDCR Recidivism Rates for First Releases



Time Served In Months	Release Year					
	2000		2001		2002	
	% Released	% Returned	% Released	% Returned	% Released	% Returned
Total	100.0%	60.6%	100.0%	59.4%	100.0%	57.3%
0 – 6	15.9%	66.0%	16.7%	63.5%	17.6%	61.9%
7 – 12	37.0%	62.6%	35.5%	62.7%	33.1%	60.1%
13 – 18	16.9%	59.0%	16.6%	57.7%	16.3%	55.7%
19 – 24	11.1%	58.6%	10.7%	57.9%	11.2%	55.9%
25 – 30	4.8%	55.6%	5.1%	54.0%	5.0%	52.4%
31 – 36	3.6%	54.9%	3.9%	53.4%	3.9%	52.5%
37 – 60	7.1%	53.9%	7.2%	49.5%	7.4%	49.8%
61 +	3.5%	56.1%	4.2%	53.5%	5.5%	51.0%

Source: Table 6 is reproduction of Table E-4 from the Expert Panel Report, at Appendix E, p. 92.

Table 7: Three Year Follow:-Up Rate of Re-arrest of State Prisoners (including California) Released in 1994, By Time Served in Prison

Time Served	3 Year Re-Arrest Rates
6 Months or Less	66.0%
7-12 months	64.8%
13-18 months	64.2%
19-24 months	65.4%
25-30 months	68.3%
31-36 months	62.6%
37-60 months	63.2%
61 months or more	54.0

Source: U.S. Department of Justice. Office of Justice Programs, Bureau of Justice Statistics, *Prison Statistics*. Online. Available: http://www.ojp.usdoj.gov/bjs/prisons.htm. Accessed: August 1, 2006.

66. The methods that many states use to reduce the LOS are either through good-time credits or parole board decision making. States with indeterminate sentencing use their parole boards to modify LOS. In a determinate sentencing state like California the [30] only means for modifying release dates is to allow for the award of special program credits that serve as an incentive to participate in risk reduction programs.[46] Illinois and Indiana are two states that offer such good time credits for most of their inmates.[47]

67. Creating an incentive system where prisoners are rewarded for complying with the facility rules and/or participating in programs that serve to reduce recidivism rates is cost effective and helps protect both institution and public safety.

68. In California there are few incentives for California prisoners to participate in programs or to fully

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[46] In the 1960s, when California had an indeterminate sentencing scheme, Governor Ronald Reagan was able to reduce the prison population by increasing the number of paroles being granted by the Parole Board and increasing emphasis on rehabilitation and treatment. During this period the prison population dropped from 28.000 in 1968 to under 20,000 in 1972 and remained at that level for several years. This practice is still being used by several states (New York. Texas, Nevada, Kentucky, Michigan, and Pennsylvania are states that have increased parole grant rates or have maintained high grant rates for a considerable period of time).

[47] *See* Illinois and Indiana Department of Corrections web sites at http://www.idoc.state.il.us/ and http://www.in.gov/idoc/

comply with prison rules. Prisoners receive a fixed term which can be reduced by varying amounts by receiving earned credits as set forth in Penal Code §2933.[48] The original intent of the work and education credits was to establish an incentive for participating in designated programs and work assignments. But as over-crowding intensified, the opportunities for such participation both decreased and was unevenly applied.[49]

69. To address this problem the CDCR has become more generous in what qualifies for work incentive credits by creating in 2004 the "Bridging, Educational Program" (BEP).[50] The BEP is a 2-4 month in-cell program offered to prisoners at the Reception Centers that awards prisoner good time credits for completing in-cell written [31] assignments. The quality of such services and their impact on recidivism rates is questionable and has not been evaluated.[51] Basically, it is a method for expediting releases by allowing newly admitted prisoners to earn Work Incentive Program (WIP) credits while awaiting a transfer to another facility or release to parole. The percentage of prisoners participating in the Bridging program has accelerated over the past few years.

70. Another method being used by the CDCR to expedite releases is its Conservation Corps Program. Prisoners who work in this program can earn two days off of their sentence for each day in the program

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[48] Expert Panel Report, page 12 for detailed description of allowed good time credits.

[49] *See* Expert Panel Report, page 12.

[50] *See* Expert Panel Report, page 12.

[51] *See* Expert Panel Report, pages 151and 177.

as authorized by Penal Code §2933.3. Currently, there are over 4,000 male and female prisoners in the Conservation Corps camps, which is less than three percent of the total institutional population.[52] Expanding these programs would decrease the LOS for prisoners who are not sentenced as a "violent" offender, 2nd striker, or a 3rd striker. (It should be noted that there are prisoners in these three excluded classes who are assigned to the CCCs but are unable to earn the additional good time credits due to existing California law. The 2nd and 3rd plus prisoners classified as serious or violent offenders must serve 80% of their sentences, so the day-for-day earned credits are of less value and are less of an incentive for them to participate in meaningful programs and adhere to the prison rules.)

71. Under current California law and practices, prisoners do not receive full WIP or pretrial credits while in the local jails awaiting transfer to the CDCR. This has resulted in a very complex, cumbersome and expensive bureaucratic system of trying to keep [32] track of the various forms of earned good time credits which is unique for determinate sentencing states.

72. Each year, tens of thousands of CDCR prisoners receive Work Incentive, Education, Vocational and Conservation Camp Credits. Expanding this program would reduce the prison population, and, if done effectively, reduce recidivism as well.

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[52] *See* http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad080716.pdf

Estimated impact of Lowering LOS

73. The Expert Panel estimated that an enhanced good time credit program would reduce the CDCR population by at least 17,000. That estimate assumed that at least 50,000 new court commitments and parole violators would receive an average of four months of program credits which would reduce the CDCR institution population by at least 17,000 prisoners. However, that estimate included prisoners outside of the 50% earning class (50% earning class are non-serious offenders who, through earning WIP credits, can reduce their sentence by up to 50%) and did not take into account the effects of diverting short-term sentenced prisoners. If one assumes that only the 50% earning class were to be impacted (57,000 admissions per year), and only half were to be able to receive an average of four months case management plan credits prior to release, the impact on the CDCR institutional population would be 9,500. This estimate would be higher if the diversion of short term new court commitments did not occur.

74. Further population reduction would occur if more prisoners were able to participate in the CCC programs and earn the two-for-one day credit.

75. California's current Work Incentive Program is deeply flawed. CDCR has attempted to maximize the effect of the WIP by creating the Bridging program, noted earlier. Today virtually all newly admitted prisoners are enrolled in the Bridging program [33] to ensure they receive the day for day WIP credits. When visiting the Lancaster facility in 2007, I was told that the Bridging program often consists of prisoners being given "assignments" to read materials or other self help documents. Credit for this work is assumed and is not evaluated to determine

what if any progress is being made by the prisoner. It was this lack of structure that led the Expert Panel to recommend that the WIP credits be made statutory which is similar to some other states. Such a change would also eliminate a cumbersome bookkeeping process that has resulted in wrongful incarcerations beyond the proper release date.

76. Finally removing the restrictions prohibiting "serious offenders" and 2nd and 3rd strikers from receiving sentence-reducing credits would significantly reduce the average daily prison population. For example, moving up the release dates of such prisoners by an average of four months would lower the prison population by over 3,000. If such prisoners could be placed in the 50% earning class category, the prison population would decline by as much as 37.000 people.[53] There are a considerable number of prisoners who are not in the 50% earning class but who are low risk and whose further incarceration has no impact On crime rates or recidivism rates.[54]

4. Early Discharge from Parole

77. Finally the state can safely reduce its prison population by offering good time credits to reduce the period of parole supervision. Similar to the research on LOS and imprisonment' there is no evidence that extending parole supervision for all prisoners serves any public safety value or reduces recidivism. In fact a California study showed no relationship between time on parole (or even the placement of a prisoner

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[53] *See* Expert Panel Report, Appendix E. page 93.

[54] Based on CDCR and UCI recidivism data files I have received since 2007.

on parole) [34] with recidivism rates.[55] The Urban Institute also recently reported that prisoners released with no parole supervision have recidivism rates that are similar to those who are placed on parole.[56]

78. These research findings suggest that the amount of time a CDCR parolee must spend on parole supervision can be significantly lowered without jeopardizing public safety. This is important in that the population-reduction options listed above will serve to place more prisoners on parole supervision for a longer period of time under current CDCR and Board of Prison Terms policies.

79. In order to reduce the number of parolees, California can implement a policy that accomplishes one or both of the following:

a. Allows prisoners to earn day for day good time off their parole supervision period for compliance with the conditions of parole (under this situation most prisoners who comply with the conditions of parole would serve no more than six months of supervision), and

b. Mandates the discharge of all persons from parole supervision after having demonstrated that the prisoner has remained arrest and violation free for a 12 month period.

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[55] Dorothy R. Jaman, Lawrence A. Bennett, and John E. Berecochea, *Early Discharge from Parole: Policy, Practice and Outcome*, Sacramento: California Department of Corrections, 1974; Deborah Star *Summary Parole: A Six and Twelve Month Follow-Up Evaluation*, Sacramento: California Dept. of Corrections Research Unit, 1979.

[56] Amy Solomon, Vera Kachnowski, and Avi Bhati. March 2005. "Does Parole Work?: Analyzing the Impact of Postprison Supervision on Rearrest Outcomes. Washington, DC: Urban Institute.

80. Under current law prisoners must complete a period of parole (usually 1-3 years) after discharge from prison. While state law allows some parolees to be discharged from parole early for good behavior, this option is rarely used and most [35] parolees are not discharged by the BPT even though they have remained arrest and violation free.[57] Implementing an effective early parole discharge program would both reduce the population of parolees and, concomitantly, reduce the parole revocation rate. *Estimating the Impact of Early Discharge from Parole*

81. At the time of writing this report, I had only just received data that will enable me to analyze the impact of decreasing the period of parole supervision for persons who remain arrest- and violation-free, and I have not had time to fully analyze this data.

* * * *

[44] 95. The effects of a good time credit program on the three counties are summarized in Table 11. In this table it is assumed that persons in the 50% earning class will receive an average of four months of credits, which will serve to reduce their period of imprisonment by the same amount. During this four month window (a time during which the inmate would have been incarcerated absent the good time release program), approximately 5% of the released prisoners will be re-arrested or returned to prison for a technical violation.[60] *The good time credit releasees*

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[57] *See* Expert Panel Report, Page 13

[60] This is based on data file sent to me by the CDCR in 2007. The figure will be updated using more comprehensive data files sent to me on August 12.2008 by the CDCR.

would account for a temporary increase in arrests of less than 1 percent °fall arrests occurring in the counties. Several months after the good time credit program is implemented, even this small and temporary increase in arrests and prison returns will disappear.

Table 11: Estimated Impact on Public Safety on Good Time Program for Selected Prisoners

Attribute	**Amador**	**Fresno**	**Los Angeles**
Total Arrests (historical)	3,193	93,084	720,959
Total Jail Bookings (historical)	1,846	42,732	173,000
Annual Releases (historical)	90	2,300	22,300
Additional Releases with good time program	9	547	5,375
% of total releases	10%	21%	24%
Additional Arrests @ 5% rate	1	28	269
% of total County Arrests	< 1%	< 1%	< 1%
% of Total Bookings	< 1%	< 1%	< 1%

Source: CDCR and California Attorney General Office.

Benefits to Implementing Population Reduction Measure

96. The population reduction options listed in this report will have a number of benefits in addition to lowering the size of the current CDCR population

[45] 97. The population reducing techniques will have the most immediate impact on crowding at CDCR's critical reception centers, which first house any new admissions. In order for any prison system to function properly it is essential that the major reception centers are not severally crowded. In the CDCR, the crowding of the male reception centers is largely a function of the large number of parole violators (especially technical violators.) who are being processed each year. By lowering the revocation rate and diverting technical violators from the CDCR, the number of admissions will decline as well as the size of the reception center populations. This will increase

the ability of CDCR to effectively screen new inmates for health and mental health concerns and also for programming needs.

98. The reduced population will also reduce the number of lockdowns caused by overcrowding, which will also increase the ability of CDCR to provide medical and mental health care and to provide evidence-based programming that will reduce recidivism.

99. Moreover, the population reduction measures outlined in this report will require no additional funding, because it is far less expensive to provide supervision and programming to parolees than to prison inmates.

100. Finally, the reforms, if implemented correctly, should have no impact on crime rates in California.

Dated August 15, 2008

/s/ James Austin
James Austin, PHD

IN THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT
OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

EXPERT REPORT OF BARRY KRISBERG, PhD

[1] Expert Report of Barry Krisberg, PhD

I. Qualifications

I have been the president of the National Council on Crime and Delinquency (NCCD) since 1983. Having just celebrated its 100th anniversary, the NCCD is the nation's oldest and most respected criminal justice research organization. I have been known internationally for my research and expertise on juvenile and criminal justice issues and I am frequently called upon by elected officials, the judiciary, and the media. The NCCD is often asked by governors and legislatures in many states to assist in designing justice programs. Most recently, I worked in Illinois, Texas, and Florida to help rebuild very troubled juvenile corrections systems. I have worked in a variety of roles in California to design and evaluate reforms in the state corrections system. My complete curriculum vitae are presented. in Attachment A.

I received my master's degree in criminology and a doctorate in sociology, both from the University of Pennsylvania. I have held several educational posts. I was a faculty member in the School of Criminology at the University of California at Berkeley and as an adjunct professor with both the Hubert Humphrey Institute of Public Affairs at the University of Minnesota and the Department of Psychiatry at the University of Hawaii. I am currently a lecturer in the Legal Studies Department and at the Boalt Hall School of Law at the University of California, Berkeley. Most recently, I gave an advanced seminar for Boalt Hall students on "Legal and Policy Issues in Prisoner Reentry."

In 1979 I was asked by Health and Welfare Secretary Mario Obledo to serve on a Task Force to investigate the over-representation of people of color in California prisons. In the 1990s I was appointed by the Legislature to serve on the California Blue Ribbon Commission on Inmate Population Management. Previously, I was asked by the Legislature to conduct a study on alternatives to prison. More recently I was asked by the California Senate Budget Committee to [2] organize a California Task Force on Prison Crowding. I also was appointed by CDCR to serve on an Expert Panel on Adult Offender Recidivism Reduction Programs.

My memberships have included the Juvenile Justice Committee of the International Association of Chiefs of Police, the National Association of Juvenile Correctional Administrators, and the Association of Criminal Justice Researchers. I was past president and fellow of the Western Society of Criminology and was the Chair of the California Attorney General Bill Lodger's Research Advisory Committee.

In 1993 I was the recipient of the August Vollmer Award, the American Society of Criminology's most prestigious award. The Jessie Ball duPont Fund named me the 1999 Grantee of the Year for outstanding commitment and expertise in the area of juvenile justice and delinquency prevention.

In 2002, I was appointed to by the California Attorney General to chair an Expert Panel to investigate the conditions in the California Youth Authority. In 2004 I was named in a consent decree to help develop remedial plans and to monitor many of the mandated reforms in the Youth Authority. I am often asked by California counties and the Chief Probation

Officers of California to provide training on a range of corrections issues.

I have numerous books and articles to my credit and serve on the editorial board of the prestigious journal *Crime and Delinquency*.

I am frequently called upon by private foundations to assist with the design, implementation, and evaluation of programs—both their own and those of the public sector. The Annie E. Casey Foundation engaged me to assess the effectiveness of their Juvenile Detention Alternatives Initiative, the single largest private program for juvenile justice system reform in the country. The Walter S. Johnson Foundation supported me to lead a Blue Ribbon Commission on California's policy of out-of-state placement of delinquent youth. Baptist Community Ministries [3] has sought my expertise on assessing the needs of troubled youth in the greater New Orleans area, and the Robert Wood Johnson Foundation asked that I prepare a white paper on delinquency and substance abuse. The California Endowment selected me to evaluate a five-county effort to improve mental health services in juvenile detention facilities. The California Endowment has also funded me to lead a 13-city network to reduce gang violence in California. The Irvine Foundation asked me to assess the value of inmate rehabilitation programs at Lancaster State Prison. Several California foundations and the JEHT Foundation funded me to conduct a comprehensive study of California women prisoners. In the late 1990s, the San Francisco Foundation funded me to examine the implementation of a new inmate classification system at San Quentin. I have been regularly consulted by the California Office of the Inspector

General, especially on issues relating to the Division of Juvenile Justice (DJJ).

I have supervised NCCD research studies funded by the National Institute of Justice on Early Release in the Illinois Department of Corrections and on the Use of Electronic Monitoring in Oklahoma. I have also been asked by the National Institute of Corrections to provide training to a number of jurisdictions on jail classification systems and to provide assistance to the District of Columbia Department of Corrections. I am regularly consulted by the Special Litigation Unit of the US Department of Justice on investigations under the Civil Rights of Institutionalized Persons Act, and I testified before the National Commission on the Elimination of Prison Rape at their request.

In the past five years, I have served as a joint expert witness in *Farrell v. Cate*, a case that involves a Consent Decree on conditions in the DJJ. In that capacity, I was deposed on April May 19, 2008 and testified in Alameda County Superior Court on April 24 and May 23, 2008. I was also deposed in July 2006 in cases entitled Fonda Whitfield and The Estate of Deon Whitfield v. State of California et al., Case No. Cv-04-2729 GEB (JFM); Allen Feaster and [4] Gloria Feaster and the Estate of Durrell Feaster v. State of California et al., Case No. CV-04-2730 GEB (NM). The cases stemmed from the January 19, 2004, suicide deaths of two young wards in the same cell, Deon Whitfield and Durrell Feaster at Preston.

II. Expert Opinions

I was retained by the plaintiffs in July of 2008 to be an expert in these proceedings and have reviewed many documents, depositions, interrogatories, and other expert reports and statistical data relevant to the Coleman and Plata proceedings. I have been asked to render an opinion on whether the accelerated release of CDCR inmates would create a danger to public safety. My fee is $300 per hour for work related to these cases.

A. Done properly, a population cap in the California state prison system would not have an adverse effect on public safety.

My extensive review of the available data reveals that millions of prisoners in other states as well as inmates in numerous California county jail systems have been released early in response to population pressures with no adverse effect on serious crime. Indeed, the most solid empirical evidence on the experience of other states that have accelerated prisoner release to reduce population is that such releases are uniformly safe and, if done properly, actually reduce crime.

1. All rigorous studies of other state prison systems' early release programs demonstrate that such programs do not endanger public safety

My opinion is based on a thorough review of empirical research over the past 22 years in states that have accelerated the release of prison inmates. In March of 2007, my colleague Carolina Guzman and I conducted an extensive review of the published literature on early release and public safety. This review utilized the library resources of the National Institute of Corrections, the National Criminal Justice Reference Service, the James Cotton-NCCD Criminal [5] Justice Collection at Rutgers University, and the Bancroft Library at the University of California Berkeley. This review identified 14 peer-reviewed articles, dissertations, state agency reports, and national studies. These materials covered the period from 1981 to 2004 and covered Canada and the states of California, Washington, Wisconsin, Illinois, Texas, Colorado, Montana, Michigan, and Florida. In addition, one study covered early releases from a large jail in the

Northeast U.S. Attachment B includes a brief overview of these 14 studies and the full citation of authors and sources.

Overall, this literature showed that the recidivism rates of prisoners released early were comparable to those who served their full terms. In some instances the recidivism rate among the early release group was lower than those inmates who served their full terms. We found that early release programs actually lowered recidivism rates of released inmates when they were targeted at selected low-risk offenders, especially those convicted of substance abuse or property crimes. Further, early release produced lower rates of recidivism if there were provisions made for community-based supportive services such as housing, employment, or drug treatment. In addition to the recidivism data, virtually all of the studies illustrated that overall crime rates were either stable or declining during the periods when prisoners were being released early. The following discussion reviews some of the specific studies in greater detail.

Washington began accelerating the parole of inmates to reduce prison crowding in 1979. The Legislature mandated that the most serious felons and sexual psychopaths could not be part of the early release program. The research covered 1,674 inmates that were released an average of 6 months early. The comparison group consisted of inmates released in the 12 months before this program. The recidivism rates of the two groups were virtually identical over the next five years. The Washington state crime rate was roughly constant during the period of the early release.

In 1970, the California Department of Corrections selected a cohort of 1,310 inmates who [6] were eligible for parole. Half of the group members were randomly selected and paroled an average of 66 months earlier than their scheduled dates. The CDC researchers found no statistically significant differences between the two groups in terms of returning to prison based on either a new conviction or a parole violation. There was no evidence that this experiment had any effect on the state crime rate.

Colorado immediately released 126 prisoners after the courts ruled that they should have gotten good time credits based on their jail behavior during presentence confinement. There were no statistically significant differences in the re-arrest rates for the accelerated released inmates compared to those who were not released. Again, there was no discernable impact on the Colorado crime rate.

The Montana legislature placed a cap on its prison population in 1993, in part, by decreasing the amount of time served by its prison inmates. The researchers examined inmates who received accelerated good time credits, those sentenced to community-based parole programs, and those who received a regular parole date. The recidivism rates of these offenders were roughly the same as historical Montana recidivism rates. During the period of the prison cap, the crime rate in Montana showed a modest decline.

A Texas study examined a sample of 2,072 prisoners released from the Texas Department of Corrections in 1983. Approximately 29% of these cases were Early Mandatory Releases—inmates selected for release up to 180 days prior to their regular release dates. The researchers found that the return rate to prison was similar for the early release cases compared to others that were released on their regular sentence dates. It was also noted that in 1983, when mandatory release was fully operating, Texas saw the largest drop in 20 years in its state crime rate.

Two studies from Wisconsin followed 1,886 inmates who received mandatory releases after being rejected for parole and another cohort of 892 inmates who were subject to Special Action [7] Release to reduce crowding. In both studies, there was no evidence that releasing selected inmates had any negative effects on recidivism or general public safety. During the course of these programs, the crime rate in Wisconsin declined by over 5% from 1984 to 1988.

With a grant from the National Institute of Justice, the NCCD conducted research on the early release program of the Illinois Department of Corrections (IDOC) that operated from 1980 to 1983. Early releases of up to 90 days were ordered by Governor James Thompson to prevent violence in Illinois's crowded prisons. By 1983, these releases had reduced the average daily population of IDOC by roughly 2,500 inmates. The NCCD study showed that the prisoners who were released early actually had a lower recidivism rate than those released after serving their full terms. Inmates were selected for early releases that were closest to their regular release dates. Wardens were asked to flag cases in which the inmates had presented significant problems while incarcerated. It might be that the early release population possessed a slightly lower risk of re-offending than the group that served their full terms, but the selection of inmates for release process was really driven by how soon inmates would be released anyway.

Illinois's crime rate declined during the years of early release. In 1990 the Illinois Legislature modified the program and actually increased the number of days to 180 by which inmates' sentences could be reduced. The NCCD examined the cases of 4,640 inmates. The early releases had the same recidivism rates as the other released inmates. The later cohort of early-release inmates actually possess lower post-prison failure rates compared to the original group of inmates with accelerated discharges (their releases were advanced to 180 days vs. 90 days). For both cohorts, the majority of subsequent crimes were for nonviolent misdemeanors. Crime rates continued to decline even as early releases were increased in Illinois.

A Michigan Task Force on Jail and Prison Crowding found that the state's crime rate continued to trend downward from 1991 to 2004. The crime drop in Michigan closely paralleled [8] the national decline in crime during this same period. This was a period in which the Governor had capped the prison population and the county jails were advancing the release of many inmates.

Under court pressures, Florida employed house arrest and intensive supervision for offenders who were otherwise bound for state prisons. Inmates usually served short prison stays of roughly 90 days and then were released to intensive community supervision. With funding from the National Institute of Justice, the NCCD studied 630 offenders in this program, known as Community Control. During an 18-month follow-up period, the offenders in the Community Control Program had a lower rate of recidivism than similar offenders who served prison terms of approximately 9 months. A larger study of Community Control was conducted by the Florida Office of Inspector General. This analysis found that the majority of released prisoners that returned to prison or jail did so because they violated conditions of supervision and not because of new crimes. As with the other jurisdictions Mentioned above, Florida's crime rate declined during the period when Community Control was operating.

Research on early parole of jail inmates in Philadelphia showed that adding in community-based drug treatment services increased the proportion of successes among the early released inmates from 66% to 78%. Those who actually completed the drug treatment programs had twice the success rate of those with less than 6 months in treatment. This study showed that while early paroled jails inmates had relatively low recidivism rates, the addition of drug treatment could substantially improve their post-release success rates.

Finally, I found in my March 2007 literature review several studies of offenders who received accelerated parole from Canadian prisons in the mid 1990s. Studies of both men and women prisoners who received early parole showed that they had relatively low post-release failure rates. These offenders did better than comparable inmates who served their full terms, and [9] the subsequent offenses were primarily violations of parole conditions, minor crimes, and overwhelmingly nonviolent offenses.

Others involved in California corrections concur with my opinion. For example, Matthew Cate, the current director of CDCR, testified that corrections experts have indicated that "if done properly," one can reduce the prison population "without negatively impacting crime rates in society."[1] Loren Buddress, Chief Probation Officer for San Mateo County, believes that, given funding to provide appropriate services, "a controlled release of inmates from state prison would not negatively impact public safety."[2] According to Sonoma County Sheriff William Cogbill, putting programs in place would reduce recidivism, and if provided with sufficient funding for programs in conjunction with a prisoner release order, Sonoma County "could mitigate those impacts to public safety to the degree that it wasn't an issue."[3]

2. Early release of jail inmates in California has not had an adverse effect on crime rates

There has been extensive use of early release and diversion in California counties in response to court orders to reduce jail overcrowding. Although these practices have not been subject to the rigorous and in-depth research that I have described above, the aggregate data supports the position that early release done properly does not weaken public safety.

I examined data from the Board of Corrections on the extent of releases of jail inmates in California counties due to court orders to manage crowding, and analyzed this data in relations to changes in the crime rates of these counties. For crime rates, I used the FBI's Uniform Crime Reports and looked at the most serious crimes that most criminologists use to examine crime trends and to compare jurisdictions. These offenses include homicide, aggravated assault, forcible rape, robbery, burglary, grand larceny, auto theft, and arson. The FBI uses these offenses [10] as an index of crime because they are among the most serious offenses, and these crimes have a high probability of being reported by citizens to the police. I will refer to these offenses throughout my report as "serious crimes." Although data on reports for misdemeanors and less serious offenses are less consistently available for all California counties, I examined 10-year trend data from the California Department of Justice on arrests for misdemeanors. From 1997-2006 the California Department of Justice reported that statewide misdemeanor arrests declined from 1,033,196 to 939, 046—a reduction of 9%. The rate per 100,000 of misdemeanor arrests dropped from 4,011 to 3,260—a reduction of 18%.[4]

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[1] Cate Deposition, page 53.

[2] Buddress Deposition, pages 50-51.

[3] Cogbill Deposition, pages 36-38 and 39-40.

I examined data on individual California counties in releases and the number of crimes, the five-year trends, and the more recent two-year trends. From 1996 to 2006, using 21 counties for which there was complete data, over 1.7 million jail inmates were released due to overcrowding.[5] These were jail inmates that the counties reported to the Board of Corrections (now known as the Corrections Standards Authority) that they had released either via diversion or shorter sentences pursuant to a court order to limit the capacity of their jails. In this same period, the number of serious crimes reported dropped by 18%. During the five years from 2001 to 2006, there were 764, 277 inmates released from 22 counties.[6] The number of reported crimes was largely unchanged in these locales. During the most recent three-year period for which complete data are available (2004-2006), there were 416,767 inmates released in 24 counties due to court orders, but the number of reported crimes declined by 7% in these same counties.[7] [11] I also analyzed the trends in individual counties but this showed no consistent relation between the volume of jail release due to court ordered population caps and changes in reported crimes across the counties. For example, from 2002-2004, 13 counties (Amador, Calaveras, Fresno, Humboldt, Inyo, Los Angeles, Orange, Placer, San Mateo, Santa Barbara, Shasta, Ventura, and Yolo) had an increase in capacity-based releases and a decrease in crime. Another 8 counties (Butte, El Dorado, San Diego, Merced, San Benito, Stanislaus, Tehama and Tuolumne) had a decrease in releases and a decrease in crime. Only 3 counties (Kern, San Joaquin, and Solano) experienced a rise in both releases and crime.

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[4] (http://stats.doj.ca.gov/cjsc_statsprof06/004A.htm)

[5] Amador, Butte, Calaveras, Eldorado, Fresno, Humboldt, Kern, Los Angeles, Merced, Orange, Placer, San Benito, San Diego, San Joaquin, Santa Barbara, Shasta, Solano, Stanislaus, Tehama, Tuolumne, and Yolo.

I looked at patterns in the largest counties (Los Angeles, Orange, and San Diego) as well as a number of mid-sized or smaller counties. Here again, no consistent pattern linked changes in crime with increases or decreases in jail releases due to court orders. Put simply, the accelerated release of jail inmates neither lowers the crime rate nor increases it. This finding is entirely consistent with the studies that I reviewed earlier in this report.

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[6] Same list as above adding in data from San Mateo.

[7] This group includes also data from Inyo and Ventura.

At the local level, testimony from corrections professionals supports the inference, drawn from the statistics discussed above, that early releases from local jails have not adversely impacted public safety. San Diego County has implemented a variety of diversion and early release programs to control the population in its county jails. William Ingrassia, Commander of the Detention Bureau for San Diego County, was unaware of any specific detriment to public safety caused by these programs.[8] Sonoma County likewise functions under a population cap, Sheriff Cogbill was unaware of any particular crimes that were committed by inmates who were released early.[9]

B. Studies show that if early releases are accompanied by resources for evidence-based programs for this population, there will be a positive effect on public safety

[12] There is a significant population of people who are safer to society if provided appropriate programs in their communities rather than being warehoused in overcrowded, violent prisons. We can generally identify these inmates who pose a very low risk of recidivism, given proven risk classification tools. Further, there are well-tested assessment tools that

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[8] Ingrassia Deposition, pages 55-60.

[9] Cogbill Deposition, pages 23-24.

can identify and prioritize the treatment needs for individual prisoners. There is a growing body of research identifying program interventions such as Cognitive Behavioral Therapy and Therapeutic Communities that produce measurable progress for inmates with various treatment needs. We can identify the programs, given numerous studies with concrete data showing positive effects on recidivism rates. It is also common sense. A low risk offender will have a better chance of succeeding in the community and becoming a productive member of society if they are enrolled in substance abuse programs or job training programs in the community. Compare this plan to the same convict sitting idle on a tripled bunk in an overcrowded, violent gym with minimal yard time and no work or educational opportunities, consorting with more sophisticated criminals or prison gangs. The CDCR's Expert Panel on Adult Offender Recidivism Reduction Programs (2007) gave numerous examples from states such as Pennsylvania, Ohio and Arizona that are making significant programs in matching appropriate services to offenders as a method of reducing future criminality.

C. The critics of early release make faulty assumptions about the relationship between correctional practices and public safety.

Arguments against accelerated release generally ignore several key facts. First, it is important that virtually every inmate selected for early release under the programs suggested by Dr. Austin in his expert reports and used in California counties under population caps will be released soon anyway. Most accelerated release programs will shorten the prison stays of inmates by six [13] months or less.

As the President of John Jay College, Jeremy Travis has reminded us in his book, *But They All Come Back*, all but death row inmates and prisoners with life sentences eventually return to the community. Although it is true that some released inmates will re-offend, being released several months sooner is not likely to have an impact on that fact. A National Research Council report, released in 2007, reviewed studies on the correlates of prisoners who recidivate and suggested that post-release opportunities including employment, housing, and positive family supports can reduce these failure rates So data on the current recidivism rates of California inmates are not especially relevant to evaluating early release. Further, respected psychologist such as Professor Craig Haney of the University of California, Santa Cruz have argued that prisons actually *debilitate* inmates, increasing their mental health problems and diminishing their abilities to function in the free world.[10] This means that longer prison stays may actually increase recidivism rates. Data from CDCR reviewed by Dr. James Austin suggests that the longer the time served the higher the post-release failure rates.

Second, there is growing evidence that careful selection of inmates for early release can improve the programs' outcomes if there are focused efforts to match inmate's needs to services in the community. Well designed and implemented programs can actually lower prison populations and advance public safety. The Pew Trusts has recently issued reports illustrating examples of this win-win situation. There are several highly effective risk and needs assessment systems that are available. For example, the NCCD approach known as Correctional Management Classification (CMC) has shown its ability to assist in the community supervision of released offenders in states such as Florida, Wisconsin, and South Carolina. Offenders who were supervised by parole or probation staff trained in CMC had much lower rates of failure than [14] other parolees. There are several valid assessment tools available to CDCR to effectively screen out the high-risk inmates and permit better community supervision.

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[10] Craig Haney, *Reforming Punishment: The Psychological Limits of Pains of Imprisonment,* Washington, D.C.: American Psychological Association, 2006.

There is solid evidence that effective services in the period right after discharge can substantially cut down on recidivism. The CDCR's own Expert Panel on Adult Offender Recidivism Reduction Programs offers a blueprint designed by nationally known corrections leaders and researchers that is based on the best available research. Further, a recent report of the National Research Council on Parole, Desistence from Crime, and Community Integration (2007) offers the best evidence-based models for cutting down on post-release crime. The Urban Institute, the Council of State Governments, and the National Institute of Corrections all have tremendous resource materials on properly managing the prison reentry process.

All of these authoritative sources have shown that the provision of transitional housing, access to health care and mental health services, drug treatment, and vocational services can ease the reentry process and reduce subsequent criminality. It is recommended that planning for reentry services occur early in the incarceration period and that offenders leave prison with specific reentry plans.

The critics of early release exploit the image of inmates being randomly dumped into communities without reentry planning or effective services. If early release is accompanied by funding for proven reentry services, it would be a safe and effective population reduction strategy, the cost of which is far less than building and operating more prison and jail beds. Further, community-based reentry programs can be up and running far more quickly. Critics have argued that such services do not presently exist in sufficient quantity at the local level, but there is no logical reason why this community capacity could not be expanded with appropriate state funding and commitment.

Several counties such as Alameda, San Diego, Santa Barbara, San Mateo, and San Francisco [15] have built sophisticated reentry strategies that merge county and state resources and involve both public and private agencies. These, counties offer a range of ideas on how the CDCR could safely manage the early release of inmates, Many of these efforts are currently being researched, but the preliminary reports from the localities have been promising. Most important, these local efforts illustrate that communities have stepped up to better respond to the needs of released inmates.

Alameda County has been operating Project Choice for several years. Current Attorney General Jerry Brown was instrumental in getting this innovative collaboration started when he was Oakland's Mayor. This program is a partnership between the CDCR, several agencies in Alameda County Government in the City of Oakland, as well as a number of community-based organizations such as the Mentoring Center. The goal is to identify offenders in CDCR who will soon be released back to Alameda County and to build individual community support plans for these offenders. The services include job placement, health care, temporary housing, substance abuse services, and peer-counseling. The Oakland Police Department, Alameda Probation Department, and the CDCR Parole Division worked collaboratively to plan and implement the program. Initially begun to reduce the failure rates of offenders released from state facilities, Project Choice also works with inmates released from the county jail.

Santa Barbara County worked with the NCCD to plan and design a community collaboration to assist released inmates from state prisons and the county jail. Funded initially by local philanthropists and the Gerbode Foundation, this program includes a consortium of non-profit organizations and public agencies such as the Santa Barbara Recovery Center. The program staff contact selected low risk inmates in advance of their release (usually 90 days) and begin joint planning with the offender about the needed services when the person returns to Santa Barbara County. Top law enforcement leadership including the Sheriff, the District Attorney, and the Police Chiefs from all major cities has been involved in the program. The Santa Barbara team [16] works closely with the CDCR Parole Division and was recently funded by CDCR to build and operate a local reentry center that will serve both state and local inmates.

San Mateo County asked the NCCD to assist a multi-agency task force to help the County strengthen its reentry services. This task force was chaired by the Chair of the County Board of Supervisors and included all pertinent county agencies and community-based groups. The initial planning was partially supported by a grant to NCCD from the San Francisco Foundation. Now the services are part of the regular county budget. San Mateo County chose to dedicate a full-time probation officer to assist in reentry planning. The County is attempting to link its rehabilitation programs in the jail to Project Bridge that connects released offenders to similar services in the community. The County is also doing a careful assessment of existing substance abuse service and looking to plug any gaps in these services.

San Diego County has received substantial state and foundation funding to strengthen its local prison reentry services. The San Diego effort is primarily focused on getting released inmates into jobs. There are also a range of supportive services including counseling, health care and housing.

San Francisco has formed an ongoing multi-agency Reentry Council under the leadership of Mayor Gavin Newsome and the Board of Supervisors. The Reentry Council, which has dedicated staffing, also includes the DA, the Sheriff, the Superior Court and the Probation Department. Many community agencies and organizations of formerly incarcerated persons meet monthly to plan new services and to ensure that existing programs for released jail inmates are well-coordinated. The SF Reentry Council has been working hard to reduce barriers to employment for low risk offenders and the Council has paid particular attention to diverting low level offenders from jail sentences.

Besides the reentry programs that I have briefly described above, there are many county jail [17] systems in California that have responded to court-imposed inmate releases have employed a broad range of programs as safe alternatives to total confinement. Attachment C illustrates the extent of court-imposed releases and lists the sorts of programmatic alternatives that have been employed. The interrogatories gathered from most of the intervenor counties offer detailed policy and procedures being used in these counties for home electronic monitoring, work programs, county parole, or work furlough programs, weekend work programs, house arrest, day reporting programs, and drug treatment placements, to name a few existing alternatives. There is also information from the counties about inmate classification systems that are being used to identify the lower-risk inmates for these alternative programs. A recent report by the Chief Probation Officers of California (2007) entitled, *Adult Services Plan: Serving 18-25 year olds—Best Practices* contains an range of excellent programs that California probation leadership assert would allow them to divert many offenders from state prison, if funded appropriately.

Third, some skeptics of early release also suggest that modest reductions in sentences will have a significant impact on the deterrent value of the penal system. The research on deterrence by Franklin Zimring and Gordon Hawkins[11] suggests that it is the timely application of penalties, rather than their severity that exerts a real deterrent effect. There is no reliable scientific evidence showing that minor reductions in time served compromise the deterrent value of the penal system.

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[11] Franklin Zimring and Gordon Hawkins, Deterrence: *The Legal threat in Crime Control*, Chicago: University of Chicago Press, 1973.

Reviewing CDCR data reported in *California Prisoners and Parolees* reveals that between 1978 and 2007, the median time served for prisoners who were committed for property crimes and many drug offenses actually went down. The corresponding median time served for violent offenders and serious sex offenders went up during that same time period. But, the state witnessed a drop in crime for both violent and nonviolent offenses. The largest crime decline was [18] for burglary. (California Department of Justice 2007, *Crime in California*, Sacramento, California, 2008.)

The extent of time reductions for good behavior for nonviolent offenders has been changed repeatedly. The Legislature has changed the criteria for prison commitments versus sentences to county jails. However, there is no empirical research showing a clear relationship between these sentencing changes and crime rates, especially for the property offenders and minor offenders who would be subject to early release orders. The notion that modest early release will embolden potential offenders is more an "urban legend" than an established fact. Sentences and time served have varied over time, and they vary across jurisdictions. Current penalties are based on political decisions of state officials, not on the science of penology.

D. Defendants' expert Dr. Marquart makes significant errors in his report

I have reviewed Dr. James Marquart's expert report of August 14, 2008, and Dr. James Austin's expert report of August 27, 2008. I fully agree with Dr. Austin's criticisms of Dr. Marquarl's report, contained in pages five through eight of Dr. Austin's report.

Concluding Observations

There are a wide variety of methods though which the CDCR could provide some relief for its severe crowding crisis. These approach encompass programs and policies that either divert offenders from admission or re-admissions to CDCR or those measures that would modestly reduce the time served for non-violent and non-dangerous offenders. Both strategies have been safely and successfully employed in a number of other states and in California over the past 25 years. Moreover, many California counties faced with severe crowding and court-mandated capacity-limits have successfully diverted or accelerated the releases over 1.7 million jail inmates over the past 10 years. Crime rates went down during that same time frame.

Prison and jail population and recidivism reduction programs can be successful in relieving [19] population pressures and keeping the public safe if they include (1) effective screening through validated risk and needs assessment tools; and (2) the provision of services in the community including transitional housing, mental health and health care, and substance abuse counseling. Under these circumstances the recidivism rates of diverted or released offenders is often lower than for those who complete their regular terms. But, it must be added that the best research does not show public safety problems that have been created by early release programs, even if the community treatment or supervision resources are not increased.

The current recidivism rates of released CDCR prisoners are quite high. Further, there is ample evidence that the level of crowding has contributed to a high level of violence within CDCR's institutions. Both inmates and staff have been victims of this prison violence. Moreover, the present inadequate system of prison mental health care and the idleness of many inmates make it more likely that these recidivism rates will remain high. Thus, the status quo that is made worse by severe crowding is threatening to community safety. A better managed and designed penal system could help California reduce risks to the public.

September 8, 2009

/s/ Barry Krisberg, PhD
Barry Krisberg, PhD

REPORT OF JOSEPH LEHMAN

Coleman v Schwarzenegger et al.,

No. Civ. S-90-0520 LKK

Plata v. Schwarzenegger et al.,

No. C01-1351 T.E.H.

AUGUST 2008

[1] REPORT OF JOSEPH LEHMAN

A. Background

1. I have over 35 years of experience in corrections, parole and probation, including managing adult prison systems and adult probation programs. I have fifteen years of experience running three state correctional systems in Washington State (1997 to 2005), Maine (1995 to 1997) and Pennsylvania (1990 to 1995).

2. In addition to correctional positions, I have been a Commissioner on the Pennsylvania Commission on Crime and Delinquency, a member of sentencing commission in two states (Pennsylvania ex-officio) and Washington. I have been President of the Association of State Correctional Administrators and co-chair of the Washington State Law and Justice Advisory Council. I have received the Michael Francke Award for Excellence from the Association of State Correctional Administrators and the E.R. Cass Award from the American Correctional Association, among others. I have a B.A. from Saint Martin's College and an M.A. with an emphasis in Criminal Justice from Pacific Lutheran University. A complete description of my background is contained in my resume, which is attached hereto as Exhibit A.

3. In the last four years, I have not testified as an expert witness.

4. In December 2006, I was appointed by the State of California as a member of the CDCR Expert Panel on Adult Offender and Recidivism Reduction Programming. That panel produced a report to the California Legislature in June [2] 2007, entitled *A Roadmap for Effective Offender Programming in California*. Joint Pls Tr. Ex. 2 (Expert Panel Report). To produce that report the panel including myself, toured California prisons, were provided numerous documents and heard presentations from many officials within the CDCR.

5. I have been asked by the attorneys for Plaintiffs in both of these cases to express an opinion about whether the California prison system is overcrowded and the effect that overcrowding generally has on the provision of medical and mental health care. I also have been asked to express an opinion about whether a meaningful reduction of the prison population can be accomplished without any significant risk to public safety.

B. Overcrowding in California's Prisons

6. There is no question that California's prisons are overcrowded. As of July 23, 2008. the institution population was 155.096 or 195.3% of design capacity. (CDCR, Data Analysis Unit, Weekly Report of Population, July 23, 2008.) I agree with Governor Schwarzenegger and others that this is an emergency situation; it calls for drastic and immediate action.

7. I am familiar with the effects of prison overcrowding. During my tenure as Secretary in Washington and Pennsylvania, the prisons in those jurisdictions were overcrowded.

8. The kind of severe overcrowding that is present in California's prisons affects the entire operation of a prison and a prison system. First, it is very dangerous for prisoners and staff. "'The overcrowding of CDCR facilities has led [3] to increased numbers [of] infectious disease outbreaks and riots and disturbances system-wide." ' (Expert Panel Report at 9.) Second, overcrowding places intolerable burdens on the staff and the facilities, with significant negative impacts on the CDCR's ability to provide prisoners with all the necessary services, including health care. Third, prison overcrowding in many respects makes the prison classification system meaningless. The classification of inmates becomes no more than a drill to find an empty bed. This results in a greater risk of violence and the inappropriate housing of prisoners who need health care services. In terms of health care, the overcrowding creates a likely situation where only those prisoners who have the most obvious health care issues are classified appropriately. In many respects, in an overcrowded system the classification process focuses only on the behavior of the prisoner, particularly whether he is gang related and presents a potential for violent behavior. Certainly, in this environment the needs of the individual are secondary.

9. The conclusion the Expert Panel reached with respect to rehabilitation is equally applicable to health care: "[The] incidences of violence and other negative consequences of overcrowding degrade the CDCR's ability to consistently operate rehabilitation programs in the prison environment. While lockdowns and controlled movements allow the CDCR to increase the safety of its correctional officers and prisoners, when wardens enact these security measures, they cancel all programming in the affected prison areas. " (Expert Panel Report at 9.)

[4] 10. Overcrowding affects virtually every aspect of a prison's operation. Severe overcrowding, like that affecting California's prisons, results in a lack of treatment and office space, decreased access to health care services, and the cancellation of such services during lockdowns. In lockdown situations staff often have to escort prisoners to their appointments or activity, which makes the strain on the staff even more acute. Because of the strain on the staff, they must then choose between conflicting needs of the prisoner. I found during my tours that significant portions of program space were being used to house prisoners. Overcrowding thus reduces the opportunity for prisoners to program, which causes the obvious idleness 1 observed in a large segment of the population. That in turn leads to frustration, tension and increased violence among the prison population.

C. The California Prison Population Can Be Reduced Safely

11. The first recommendation of the Expert Panel is to reduce overcrowding. (Expert Panel Report at viii.) The panel included as members James Gomez, former Director of the California Department of Corrections, Reginald Wilkinson, former head of the Ohio prison system. Steven lckes, Deputy Director of the Arizona Department of Corrections, Jeffrey Beard, Secretary of the Pennsylvania Department of Corrections, Mark Carey, President of the American Probation and Parole Association, Joan Petersilia, Ph.D., an expert retained by Defendants, and Marisela Montes, then Chief Deputy Secretary for Adult Programs for the CDCR. (Expert Panel Report at ii.) As Chair or the Model Program Sub-Committee, I proposed that recommendation, and continue to [5] believe that a reduction in the population is a

necessary condition for providing rehabilitation in the California prison system. The Expert Panel concurred in that recommendation. The same recommendation holds true for providing other services, especially medical and mental health care,

12. The Expert Panel, mainly through the work of Dr. Petersilia, reviewed fifteen reports that had been written since 1990 on the subject of the crisis in California's prison system. Dr. Petersilia found that all of the reports made the same ten recommendations, which we endorsed:

a. Stop sending non-violent, non-serious offenders to prison. This particularly pertains to technical parole violators, who could better be served in community based, intermediate facilities.

b. Once in prison, use a standardized risk and needs assessment tool to match resources with needs and determinate appropriate placements for evidence-based rehabilitation programs.

c. Develop and implement more and better work, education, and substance abuse treatment programs for prisoners and parolees.

d. Reform California's determinate sentencing system to reward prisoners for participating in rehabilitation programs and [6] allow the system to retain prisoners who represent a continued public safety risk.

e. Move low risk prisoners to community based facilities toward the later part of their sentences to foster successful reintegration and save, more expensive prison-based resources. Sub-populations, such as women, the elderly and the sick, are ideal candidates.

f. Create a sentencing policy commission or some other administrative body that is authorized to design new sentencing statutes into a workable system that balances uniformity of sentencing with flexibility of individualization.

g. Reform California's parole system so that non-serious parole violators are handled in community-based intermediate facilities and more violent parole violators are prosecuted for new crimes.

h. Create viable partnerships between state and local corrections agencies that would expand sentencing options, enhance rehabilitation services, and strengthen local reentry systems. Suggestions have been made that include Community Corrections Acts (to get greater funding for local criminal justice initiatives) and a Community Corrections Division of the CDCR charged with developing alternatives.

[7] i. Evaluate all programs and require that existing and newly funded programs are based on solid research evidence.

j. Promote public awareness so that taxpayers know what they are getting for their public safety investment and become smarter and more engaged about California's prison system.

(Expert Panel Report, Appendix A.)

13. The Expert Panel Report also recommended that the prison population be reduced through the more aggressive use of in-prison credits, the early discharge of some parolees and the selective use of

parole for only certain offenders. (Expert Panel Report at 11-13, 41-43.) The panel found, and I concur, that if implemented properly these measures would reduce the prison population without any significant adverse affect on crime in the community. As the panel found, "it has been widely established by a number of studies, including those conducted by the US Department of Justice and the CDCR. there is no relationship between time served and recidivism (US Department of Justice. 2006). Therefore, releasing prisoners early as a result of earning program credits will not increase their recidivism rates." (Expert Panel Report at 92.)

14. Indeed, in Washington State parole was abolished in 1984 and the law was changed so that offenders could not be sent to prison for probation violations. From 1984 to 1986, the court made certain changes to the sentencing laws retroactive and increased the amount of credits that prisoners were entitled to, creating a situation that caused prisoners to be released "early" in a relatively short [8] period of time. This early release did not have any significant impact on the crime rate or the rate of recidivism.

15. While I was Secretary we were directed by the Legislature to institute a system for parolees that allocated parole resources based on risk that an offender would commit a new crime, as measured by a risk instrument. In this system, low risk parolees and probationers were not supervised at all. This allowed the Department of Corrections to concentrate its resources on those parolees most likely to commit serious crimes in the future. In my experience, only a handful of the low risk offenders who were not supervised were subsequently convicted of violent

crimes, and those were for assaults without a major injury.

16. Washington State also had a number of laws that prevented parole violators and certain felons from clogging up the prisons. Technical parole violators were not sent back to prison at all, but were placed county facilities. In addition, another law diverted certain categories of low risk felons to the county by prohibiting the courts from sentencing them to prison. In my opinion, both of these measures controlled the prison population while not having any significant adverse effect on public safety.

17. Washington State has a legislatively created Institute for Public Policy, which conducts research on criminal justice issues, among many other things. In a report entitled *Evidence-based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates* (October 2006), the Institute noted many programs that can be instituted in the community and in [9] prison that effectively reduce recidivism (some by as much as 18-20%), thereby lowering the prison population and the cost of the punishment. I believe that many of these programs could be instituted safely by California.

18. In Pennsylvania the state made changes to sentencing guidelines to allow for restorative and intermediate sanctions, such as fines, restitution, probation, residential treatment programs and house arrest. Part of the intent of these changes was to reduce the number of offenders who were sent to state prison. In my opinion and experience, these changes did not result in any increased harm to the public; in fact, in general they benefited both the community and the offender.

D. Conclusions

19. In my opinion. California must act quickly and decisively to reduce its prison population so that prisoners receive the health care services to which they are constitutionally entitled. I have no doubt that the overcrowding crisis in California's prisons can be resolved without having a significant adverse impact on public safety.

20. I have reviewed a memo authored by Deborah Hysen, the head of the CDCR's Facilities Strike Team, appointed by the Governor to implement the extensive AB 900 building plans. Joint Pls Trial Ex. 74 (Validation of In-Fill Bed Plan, AB 900 Strike Team Issue Memo No. 1, August 13, 2007). In that memo. Ms. Hysen states (on pages five through six) that AB 900 infill bed construction should not exceed 145% design capacity, and that in its Master Planning process, [10] the CDCR should ensure that prisoners not be housed at higher than 130% design capacity in the future, a number based on national standards. I agree with Ms. Hysen. In my opinion and in my experience, housing California prisoners at 130% design capacity will give prison officials and staff the ability to provide the necessary programs and services for California's prisoners.

21. I have reviewed the report submitted by James Austin, Ph.D, which discusses the effects of various prison population reducing measures on public safety. I agree with his conclusions that if such measures are properly implemented, the prison population can be reduced, and the community as well as the prison system will be safer. This does not mean that some offenders released from prison "early" will not commit crimes. That happens now with offenders streaming back into the community no better and

often worse off than when they went to prison. There is no need to choose between dangerously overcrowded prisons, on the one hand, and less crowded prisons but more crime, on the other; the question instead is whether California can maintain or reduce crime levels and at the same time run a less crowded prison system. Experience and research in other states throughout the country says that it can.

Dated: August 15, 2008

/s/ JOSEPH D. LEHMAN
JOSEPH D. LEHMAN

SUPPLEMENTAL REPORT OF DOYLE WAYNE SCOTT

Coleman v. Schwarzenegger et al.,

No. Civ. S-90-0520 LKK

Plata v. Schwarzenegger et al.,

No. C01-1351 T.E.H.

AUGUST 2008

[1] Supplemental Report of Doyle Wayne Scott

1. I submit the present report to supplement my report dated November 9, 2007. Since writing that report, I have not authored any publications. I have not testified as an expert witness in court, but I have testified in one deposition: my deposition taken in this case, on December 14, 2007.

2. Neither my curriculum vitae nor the rate my company, MGT of America, is charging plaintiffs for my work on this case, has changed.

3. Since completing my expert report for this case in November 2007, I have toured four more California prisons: Folsom State Prison (Folsom) and the California State Prison-Sacramento on June 3, 2008, and the California State Prison-Solano (Solano) and Deuel Vocational Institution (DVI) on June 4, 2008. On these tours, I was allowed open access to staff, prisoners, medical and custody records and information. I was not blocked from speaking to any staff or asking any question, and all of my questions were answered. I have also reviewed additional documents, listed in Appendix A to this Supplemental Report.

Overcrowded conditions continue to endanger health and safety of California's prisoners

4. The additional tours and documents serve to confirm the conclusion in my original report: California's prisons remain drastically overcrowded, which makes the state unable to keep prisoners and staff safe and to provide for the health care needs of prisoners. I agree with former CDCR Secretary Jim Tilton, that the overcrowding—and [2] the use of dayrooms, gymnasiums, hallways, and other inappropriate places for housing prisoners—"has reduced the availability of program and recreation space that is essential for positive inmate programming. There is widespread agreement among correctional experts that chronic idleness produces negative psychological and behavioral effects in prison." Joint Pls' Trial Ex. 72 at 15 (CDCR Presentation to the Senate Select Committee on Prison Population Management and Capacity, August 1 5, 2006). I further agree with Mr. Tilton that

> [i]dleness-related frustration increases the probability of interpersonal conflict and assaults in prison. Overcrowding simultaneously reduces the opportunities for staff to effectively monitor inmate behavior and drastically limits the options to reduce animosities between inmates by separating them or sending them to different facilities. Thus, there is less for inmates to do, fewer outlets to release the resulting tension, a decreased staff capacity to identify inmate problems, and fewer options to solve them if and when they do.

Ibid. Moreover, my assessment of the present situation in California's prisons comports with Mr. Tilton's in 2006: "the risk of catastrophic failure in a system strained from severe overcrowding is a constant threat . . . . [I]t is my professional opinion this level of overcrowding is unsafe and we are operating on borrowed time." *Ibid.*

5. Prisoners continue to be housed in unacceptable conditions that endanger their health and safety. Prisoners in Folsom (in Building Two) were double-celled in six-by-eight foot cells, with two bunks, a toilet and sink, and a desk crowded into the cells with the two prisoners. There was hardly any unencumbered space in those cells, and they were extremely narrow. Prisoners in these units spent very little time outside these [3] cells. There were no dayrooms in the units. Although there was a large yard, they spent little time on it and what time they spent was in groups of several hundred with very few staff (I saw only one staff on the yard on my tour.) It is inhumane to warehouse prisoners two to a cell under such conditions.

6. Inadequate out-of-cell or out-of-gym time was a common complaint on these recent tours, as on my first round of tours. Staff at Solano told me that administrative segregation prisoners do not receive even the required 10 hours per week of outdoor recreation, because there is simply not enough space available to provide them access to safe exercise.

7. Cells in Folsom's Building Five were seven by nine feet, double-celled, and had solid metal doors. These doors make direct supervision extremely difficult—staff cannot tell what is going on in the cells. Under these circumstances, staff are even less likely to be able to respond appropriately to medical and mental health emergencies, given their inability to See what is happening in the cells, which delays response (because they will need appropriate security

and staff to be able to open the doors) and increases mistrust.

8. These cells doors were also individually keyed on the first tiers, making quick exit in an emergency extremely difficult and escorts far more time-consuming and staff-intensive. The staffing on these units was inadequate, given the solid doors.

9. Nontraditional or "ugly" beds are still very much a common practice in [4] California's prisons. A converted gymnasium at Solano (H Building) contained 225 triple bunks—a wall of sound and bodies and noise. As was often the case in areas with significant numbers of people housed where people were never intended to be housed, many of the over-used toilets and showers were broken. Z Dorm at DVI was a similar mass of people.

10. DVI, a reception center for the San Francisco Bay Area, is extraordinarily overcrowded. The design capacity is 1700 and the count, the day I was there, was just short of 4000. All but approximately 640 prisoners were there for reception processing. The prison is so overcrowded that prisoners being released are carefully timed with new arrivals so that beds are immediately swapped. Every available space was in use for offender housing: most dayrooms at DVI are used for offender housing. I saw dayrooms with 40 inmates in double and triple bunks, using showers in the bottom tier of the associated cellblock, There were beds along all the outer Walls and in the central area, leaving just enough space to walk, but not enough to do anything else. There was no recreation space at all.

11. The Receiver has written extensively about how the physical structure of CDCR facilities poses a serious barrier to delivery of adequate care:

> The facilities available for providing health care services within CDCR are woefully inadequate. Through years of neglect, the facilities have long since passed the time when modest investments could remedy the problem. We are dealing not with deferred maintenance, but with some facilities that are literally falling apart. In addition, investments in health care facilities have significantly lagged behind growing initiate populations, so much so that available clinical space is less than half of what is necessary for daily [5] operations.

Joint Pls Trial Ex. 56, Exhibit 1, at 25 (Federal Receiver's Turn-Around Plan of Action, June 6, 2008, attached as Exhibit 1 to Receiver's Eighth Quarterly Report.) The Receiver has also documented serious problems resulting from the custody understaffing that I discussed in my initial report, noting that "[s]ystem-wide, CDCR lacks the custody staff and organizational structure and processes to ensure that patient-inmates are reliably escorted and/or transported to medical appointments. As a result, patient-inmates are often denied timely access to health care services, substantially increasing the risk that patient-inmates' health will further deteriorate and increasing the overall costs of providing health care services." *Id.* at 5. Several examples he provides are worth quoting at length, because they demonstrate the serious harms to prisoners and staff that result from the understaffing that follows from the current overcrowding crisis:

> Information obtained continues to underscore the serious repercussions of the deficient numbers of custody staff to supervise clinic operations and medication administration to patient-inmates, For example, at one level III/IV institution, a facility clinic was left unsupervised while the correctional officer escorted a patient-inmate back to the housing unit. While the officer was away several prisoners attacked and viciously stabbed a rival gang member 13 times while secured within the holding tank in the facility clinic. At another institution, investigators pursuing suspected criminal conduct in a facility clinic caught patient-inmates stealing syringes and other medical supplies via surveillance cameras. This facility clinic did not have correctional officer posts allocated for the supervision of patient-inmate movement inside the clinic areas.

Joint Pls Trial Ex. 67 at 12-13 (Receiver's Seventh Quarterly Report).

> At present, the CDCR does not have any housing units designed to adequately provide for the needs of developmentally disabled prisoners. [6] Patient C was a 36 year old prisoner with the functional IQ of a nine-year old, and documented seizure disorders. An adaptive evaluation dated July 14, 2005 required "close supervision" in order to remind Patient C to take his medications. However, instead of being placed in a medical sheltered living unit (no such facilities exist in CDCR), Patient C was confined to an overcrowded dormitory in one of California's most deteriorated prisons. In late 2007, Patient C began to encounter problems with medication management and his behavior. On November 9,

> 2007, as the result of an alleged battery, Patient C was transferred (without his medical records) to a nearby high security prison administrative segregation unit. Thereafter, between November 9, 2007 and January 4, 2008, Patient C "missed" four medical appointments (the exact causes for the "missed" appointments is currently under investigation). On January 17, 2008, Patient C returned to dormitory housing; however, there is no indication that the necessary close supervision to remind him to take his medications was provided. Indeed, given the age and structure of the dormitory, and the limited staffing at this facility, it does not appear reasonable to expect minimally adequate care for developmentally disabled prisoners to be delivered at the prison where he had been housed. On January 27, 2008 another prisoner in the dormitory reported to correctional officers that Patient C was having a seizure, Prisoner C died the same day.

Joint Pls Trial Ex. 56 at 48-49 (Receiver's Eighth Quarterly Report).

12. By placing prisoners in such settings, and requiring staff to work under these conditions, California is placing itself at serious risk, as the Governor noted in his State of Emergency Proclamation, from increased violence from enforced idleness, deteriorating mental and physical health from inadequate access to exercise and the outdoors. Further, these overcrowded conditions breed fear, anonymity, and mistrust on the part of custody staff which lead to an increased risk of inappropriate responses by such staff to medical and mental health needs, especially in emergencies.

13. I agree with the Receiver that "[c]ustody resources needed to facilitate [7] access to care and provide the security necessary to deliver health care safely in a prison setting are inadequate, lacking both the personnel and structure to ensure timely access to health care services." Joint Pls Trial Ex. 67 at 5 (Receiver's Seventh Quarterly Report).

California has no meaningful plan to fix its overcrowding problems

14. The CDCR's "Integrated Strategy to Address Overcrowding in CDCR's Adult Institutions" (Integrated Strategy) is an inadequate plan to address this crisis for several reasons. Joint Pls Trial Ex. 73. First, even if CDCR were to build the "infill" and "secure reentry facilities" they note in the plan, these spaces will not be available for prisoners to move in for years. CDCR predicts building 4,800 infill beds and 3,000 reentry beds in Phase I, and "up to" 3,800 additional infill beds and 8,000 additional reentry beds to follow. *Id.* at 3. CDCR predicts that the first 1000 infill beds will not be ready for occupancy until FY 2010/11, with the next 3,800 riot available until FY 2011/12, *See* Integrated Strategy at Chart 1A, Priority Projects, May Revision Pop. Only 500 reentry beds will be available in FY 2009/10, with 500 more the next year, and an additional thousand added for each of the next several years. *Id.* Some of the beds intended to provide relief for this emergency will not be available until 2013, *Id.* CDCR's building projects will provide prisoners with minimal relief from the emergency conditions for many years to come, an unacceptable state of affairs.

15. Second, I have serious doubts as to whether CDCR is capable of accomplishing what they set out to do in this strategic plan. The plan itself admits

that [8] "CDCR has yet to build any of the infill beds authorized by AB 900" at its passage in May 2007 because they have not been able to find Sites and because of "unforeseen limitations of infrastructure„ community concerns with prison„ expansion, staffing difficulties, and scope of construction." *Id.* at 2. These should not have been "unforeseen" problems—these are exactly the problems faced in siting and building prison facilities. CDCR's current facilities have been severely understaffed and have a severely decaying infrastructure, as I point out in my original report; local communities are always concerned with prison expansion. These problems are nothing new. This plan admits CDCR's planning shortcomings for the last several years but provides no assurances that CDCR now has the capacity to accomplish what it promises.

16. Further, the plan states that "the projects have been on hold" because of recent population projections, a budget crisis, and "settlement deliberations" in this case. *Id.* at 2-3. If the state were serious about building new facilities, and were committed to this as a meaningful solution to the crisis, it would not make such excuses.

17. Third, the infill bed numbers—4,800 beds in Phase I, 3,800 more in Phase II—are based on overcrowded housing—denoted on these charts as "HOC" or "housing *overcrowding* capacity," instead of "DBC," or "design build capacity." Prisoners in the new facilities, then, might not initially be living in gymnasiums or hallways, as they are now, but they will still be overcrowded. California will be in the same position with the new beds as with the old, replicating the same conditions that led to inadequate staffing [9] and treatment space, inadequate out-of-cell time, and

overworked and overstressed staff and violent, frustrated prisoners.

18. The state's AB 900 Strike team concluded that housing should be at no more than 130% of design bed capacity in the long term, based on national standards. Joint Pls Trial Ex. 74 at 6 (Validation of In-Fill Bed Plan, AB 900 Strike team Issue Memo No. 1, August 13, 2007). That is a realistic and appropriate place for CDCR to be, to ensure that its prisons are safe and provide legally required services. I caution, however, that while this number might be appropriate for new construction, it should used carefully in CDCR's old, decaying facilities, with their failing infrastructure. Crowding prisoners at 130% is an appropriate goal for CDCR, speaking broadly, but some facilities might only be able to support and provide appropriate health care for smaller numbers.

19. Fourth, the integrated Strategy is extremely vague on reform provisions. The document states that CDCR's strategy "relies upon a reform component" to "effectively reduce overcrowding consistent with CDCR's mission to reduce recidivism," but does not say what that reform component is. Joint Pls Trial Ex. 73 at 5 (CDCR's Integrated Strategy). In fact, CDCR has not even decided what this "reform component" will look like: "our integrated approach incorporates summary parole *or an alternative reform measure* that would safely reduce average daily population by approximately 8,000 inmates when fully implemented." *Ibid.* (emphasis added). This aspiration is a far [10] cry from an actual strategic plan.

20. Fifth, the plan says nothing about funding sources for any of the building or reform components. Although AB 900 does provide some funding, it is not clear to me that it would cover all of the building

proposed in this plan and in particular, the undefined reform components. California's current budget crisis shows that unfunded promises are very risky propositions.

21. The bottom line was stated properly by Mr. Tilton, in a statement currently on the CDCR's website; I would simply add medical care to his list of mental health care, education, and other basic needs that cannot be supplied under current conditions: "[t]he Department of Corrections owns the responsibility to assist inmates who are willing, to change their ways with basic tools, of education. Life skills, drug treatment and mental health, so they can get better when they leave Corrections—not worse. But until I get overcrowding reduced—then I don't have the opportunity to provide the program that I believe is my charge." (Viewed on the CDCR website on August 6, 2008, at http://www.cdcr.ca.gov/News/ Background_Info.html)

Date: August 13, 2008

/s/ Doyle Wayne Scott
Doyle Wayne Scott

Report of Doyle Wayne Scott

November 9, 2007

[1] Report of Doyle Wayne Scott

1. I am an expert consultant on corrections management, staffing, and security. I served for more than 30 years with the Texas Department of Criminal Justice (TDCJ), the agency that runs the state's prisons, and the Texas Board of Pardons and Paroles, culminating in an appointment as the Executive Director of TDCJ from 1996-2001. I have performed independent reviews and expert analyses on staffing patterns, institutional response to violent disturbances, general operations, and security controls for the National Institute for Corrections, the Oklahoma Department of Corrections through a contract issued by the Oklahoma state legislature, the Florida Department of Corrections, the New Mexico Department of Corrections, the Cook County judicial Advisory Council, the Indiana Department of Corrections, the Kentucky Department of Corrections, and the Puerto Rico prison system, the latter on behalf of the federal district judge overseeing reforms due to constitutional violations. I have served as the Vice-Chair of the American Correctional Association's Standards Committee and the Chair of the Legislative and Legal Issues Committee of the Association of State Correctional Administrators.

2. I have not authored any publications in the last ten years. I have not testified as an expert witness in the last four years in court or by deposition. My company, MGT of America, is charging Plaintiffs $250.00 an hour for my work on this case. My Curriculum Vitae is attached as Appendix A.

[2] I. California's severely overcrowded prison population far outstrips the ability of the system to safely or appropriately house its prisoners

3. The overcrowding crisis in California is, in my experience, unprecedented in scope and in the dangers and deprivations of day-to-day life in the prisons. My extensive experience in running the Texas prison system and evaluating management, staffing, and security needs in multiple state and local jail systems, as well as my review of numerous reports regarding California's prisons from diverse and credible sources, and my tours of four California prisons, lead me to the conclusion that without substantially reducing its prisoner population, California will never he able to generate the custodial support services necessary to provide prisoners with basic medical and mental health care.

A. The Texas experience demonstrates the impossibility for systemic reform in these areas under current overcrowded conditions

4. Next to California, Texas is the largest penal system in the United States and one of the largest in the world. When I started as a correctional officer in 1972, the system was severely overcrowded, reaching "over 200 percent of . . . original design capacity" by 1980, the year the overcrowding, health care, and many other aspects of the system were declared unconstitutional. *Ruiz v. Estelle*, 503 F. Supp. 1265, 1285 (S.D. Texas 1980). As Judge Justice found 27 years ago, the Texas Department of Corrections

> has been, by the admissions of its own officials, severely overcrowded since at least March of 1977. The problem has reached crisis proportions. When Director Estelle testified in August

> 1979, he reported that approximately 1,000 of the system's 26,000 inmates were sleeping on the floors of TDC institutions. These supernumerary inmates are housed in cells and dormitories already holding almost double the number of persons for which they were designed.

[3] *Id.* at 1277. The judge described the situation as "intolerable" and, in particular, noted that "[t]he population density of inmates confined in dormitories is shocking," *id.* at 1278, with "sanitary and recreational facilities" that were "wholly inadequate . . ." *Id.* at 1279.

5. Judge Justice issued population controls as part of the relief in Ruiz. *See, e.g., id.* at 1387. As a corrections manager and later the system's executive director, I firmly believe that population control was absolutely necessary in our decades-long efforts to correct the systemic violations. We were able to remedy the serious harms by reducing our offender population to reasonable capacity limits agreed to by the parties that allowed the Texas Department of Corrections to properly classify and manage its inmates and their attendant needs. These limits or "caps" were calculated at five percent less than the original design capacity of each institution. Those "caps" were later memorialized in legislation passed by the State of Texas that made those limitations permanent.

6. California today is far more overcrowded than Texas ever was. It is the worst overcrowding I have ever seen, in my decades of work in the severely overcrowded Texas system and in subsequent expert consultant reviews of staffing, security, and management functions in prison systems in Oklahoma, Indiana, Florida, New Mexico, Kentucky, Cook

County, and Puerto Rico. Based on my experience, I was prepared to see crowded conditions, fraying infrastructure, and management failures in California's prisons. As the head 'of a similarly huge and complex penal system, and as an employee of that system as it struggled with severe overcrowding, I know that it is impossible to run such an [4] operation properly under such circumstances. However, I was shocked by what I saw in the four California prisons I toured. These tours confirmed the profoundly disturbing accounts that I have read from the Court, the Governor, California Department of Corrections and Rehabilitation (CDCR) officials, the *Plata* Receiver, the Legislature, and the Office of the Inspector General.[1] Not only are California's prisons operating under a state of emergency, it is clear to me that unless the population is reduced, the state will remain in crisis verging on, catastrophe and will remain utterly unable to provide adequate medical and mental health care to the prisoners in its custody.

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[1] I personally toured four of California's 33 state prisons in October 2007: Avenal State Prison (Avenal), California Institution for Men (CIM), Valley State Prison for Women (VSPW), and California State Prison at San Quentin (San Quentin). These prisons represent a range of the most important variations in the system: men's and women's facilities; Reception Centers, general population units, specialized mental health units, condemned housing, and administrative segregation housing; dormitory, gymnasium, dayroom, hallway, and celled housing; high, medium, and low security; and old and more recently built structures. In addition, I have reviewed reports as noted in Appendix B from a wide range of credible and impressive sources, describing and analyzing individual prisons as well as systemic issues. My review of these written materials gives me confidence that my observations at the four prisons I toured are truly representative of the systemic failures described in this report.

B. California's prison population has expanded tremendously in the last 30 years without the infrastructure, staff, or management capabilities to support it

7. The last few decades have seen extraordinary growth in California's prison population. The population has grown more than 500 percent in less than 30 years, and—the number of prisons has nearly tripled. *Plata* Pls. Trial Ex. 1 at 4 (*Plata* Findings of Fact and Conclusions of Law Re Appointment of Receiver). Today, California houses [5] 171,285 prisoners; its prisons are at 203.7 percent of design capacity. Joint Pls' Trial Ex. 25 at. 1. (Weekly Report of Population, October 31, 2007).

8. The state has proven itself unable to address the increasing health care needs of the expanding population. As the population has grown, the state's prison infrastructure, staff, and management have stretched beyond the breaking point, resulting in the current state of acute crisis.

1. "Ugly beds"

9. It is impossible to grasp the scope of California's crisis without understanding the plight of the thousands of prisoners confined to "ugly beds." Before I describe the specific strains on infrastructure, staffing, and management, I would like to paint a picture of some of the stark realities of life in today's California prisons.

10. As the prison population has grown, it has outstripped the available space for safely housing prisoners. As a result, California has started in recent years to house more and more prisoners in so-called "ugly beds." According to the Governor, as of October 2006, "the CDCR is required to house more

than 15,000 inmates in conditions that pose substantial safety risks, namely, prison areas never designed or intended for inmate housing, including, but not limited to, common areas such as prison gymnasiums, dayrooms, and program rooms. . . ." Joint Pls' Trial Ex. 1 at 1 (Governor's Emergency Proclamation). Six months later, that number had risen to more than 16,000, which [6] "means that about 10 percent of the prison population is currently housed in 'bad' beds." Joint Pls' Trial Ex. 13 at 2 (Senate Budget and Fiscal Review Committee Subcommittee No. 4, Agenda of April 12, 2007). "Ugly beds" are not merely uncomfortable, they are actually dangerous: they make it harder for staff to prevent violence and breed anger and frustration among prisoners by sharply curtailing the space available for anything but the warehousing of bodies. *See, e.g., id.* at 2.

11. These "ugly beds" are tally appalling. I saw cages at the California Institution for Men (CIM) where, as staff freely admitted, prisoners have sometimes had to spend the night because there were no beds for them. In more than 35 years of prison work experience, I have never seen anything like it. These cages are in wide hallways with busy foot-traffic. They are only a few feet wide, and there is no room for a mattress, so prisoners have to sleep sitting on a bench. There are no toilets, and staff shortages would lead prisoners to wait lengthy periods to be escorted to bathrooms. It is difficult to properly hydrate prisoners in such a setting. These cages are an inhumane and unacceptable result of severe overcrowding.

12. At the same prison, I saw 54 prisoners in Sycamore Hall double-bunked and stuffed into a dayroom intended for recreational purposes. They

had only one toilet. Also at CIM, I saw a shockingly overcrowded gymnasium at the East Facility. Such facilities are supposed to be temporary housing, but staff told me that some prisoners are there up to a year. It was a sea of people: 202 prisoners, with only seven showers and 11 working [7] toilets. These numbers violate contemporary correctional standards for safe and hygienic facilities, as discussed in Section I.B.2, below.

13. At the California State Prison at San Quentin (San Quentin), I saw a gymnasium converted to inmate housing with 328 double bunk beds. There were only nine working toilets to service this entire population: Similarly, Dorm 410 at Avenal State Prison (A venal) was designed for 172 prisoners but has a current population of 344, some housed in triple bunks.

14. My observations are entirely consistent with the findings of the *Coleman* Special Master, who found shocking living conditions for many mentally ill prisoners. For example, Deuel Vocational Institution (DVI) "was old and overcrowded. . . . A large room around the perimeter housed 38 [mentally ill] inmates in a triple-bunk arrangement. They reported that, the room had a single toilet, urinal, and shower. Inmates were observed dumping water into, a drain from a 30-gallon garbage can which they used as a shower supplement. Many windows were broken. Inmates reported that they used blankets to cover windows but that custody officer removed the blankets without replacing them, leaving the area cold and the beds unblanketed. An area of the [administrative segregation] building housing caseload inmates was referred to as 'deep seg' or 'the dungeon' its four cells were designed for the apparent

purpose of isolation. They had almost no outside light and were illuminated by a single light controlled by an outside switch and turned off at night. Cells were malodorous, in disrepair, and out of [8] officers' ready view. Inmates in these cells likely had no more contact with custody staff than inmates housed in [punitive segregation] or stand-along administrative segregation cells and were in much worse condition. Time out of the dorm was limited to approximately 20 minutes twice per day for meals." Joint Pls' Trial Ex. 36 at 101 (18th Special Master's Report).

15. The space inadequacies extend to treatment as well as living spaces. The *Coleman* Special Master has noted that "[e]xcessive population, thus, results in a reduction of programming space now occupied by inmate hunks[;] greater competition for use of the diminishing available space; fewer Correctional officers to permit access to the diminishing space; and, ultimately, the increasing frustration and demoralization of clinicians trying to provide treatment." Joint Pls' Trial Ex. 35 at 7 (*Coleman* Special Master's Report Regarding Overcrowding, May 31, 2007). He has documented mental health treatment taking place in closets (Joint Pls' Trial Ex. 36 at 73 (California Medical Facility)), in the middle of dayrooms (*id.* at 42 (High Desert State Prison), 55 (Mule Creek State Prison)), and on outdoor benches (*id.* at 304 (Valley State)). At the California Correctional Institution, suicidal prisoners have been held in holding cells; sonic "remained in the most frequently used holding cells for as long as three days." *Id.* at 225.

16. As the *Coleman* Special Master has noted, the "ugly beds" harm prisoners. In California's severely overcrowded system, "[a]ll inmates must spend increasingly larger [9] chunks of their days in their

cells, or much more dangerously, in one of the triple-bunked 'non-traditional' spaces. None of this is conducive to the health and well-being of any inmate, much less a seriously mentally disordered inmate/patient; it inevitably escalates the incidence of mental illness and exacerbates the condition of those already mentally fragile and vulnerable." Joint Pls' Trial Ex. 35 at 7-8.

2. Infrastructure

17. Overcrowding affects all prisoners, not just those who are triple-bunked in gymnasiums or forced to live in hallways and dayrooms. "[T]he overcrowding of the prison facilities has overburdened the basic infrastructure of the institutions resulting in sewage spills and shortages of safe drinking water." Joint Pls' Trial Ex 13 at 2 (Senate Budget and Fiscal Review Committee Subcommittee No. 4, Agenda of April 12, 2007). "[C]ritical deficiencies in . . . existing infrastructure" are found at most prisons; 20 prisons have critical drinking water system deficiencies; 18 have critical deficiencies in waste water treatment, 20 in electrical systems, and 14 in other areas: *Id.* at 9.

18. My tours demonstrated the truth of these findings. In my opinion, CIM is an incredibly old, poorly maintained, unsanitary facility with inadequate staffing and overburdened, crumbling infrastructure that must be vacated and provided significant maintenance and renovations or else simply abandoned. In its current state, it is not fit for housing human beings. Similarly, San Quentin needs a substantial infrastructure overhaul before it should house people: I saw bars rusted almost completely through, filthy [10] conditions that staff say cannot be made clean, and what was described to me as

permanent unidentified liquid dripping from upper tiers onto busy passageways. It might well cost less to build an entirely new facility than to rehabilitate San Quentin to an acceptable level, the infrastructure damage and deterioration are so severe.

19. On my tours, I saw housing units with serious deficits of toilets, sinks, and urinals by contemporary correctional standards. The American Correctional Association states that toilets should be "provided at a minimum ratio of 1 for every 12 inmates in male facilities and 1 for every 8 inmates in female facilities." Joint Pls' Trial Ex. 51 at 38 (American Correctional Association, Standards for Adult Correctional Institutions, 4th Ed.). Further, one sink should be provided for every 12 prisoners, and one shower for every eight prisoners. *Id.* at 38-39.

20. California far exceeds these minimum ratios. For example, at CIM, Sycamore Hall had 54 prisoners for one toilet and East Gym had 202 prisoners for seven showers and 11 working toilets. Avenal 410 had 344 prisoners with 14 toilets. As a correctional administrator, I find that such deprivations are not only inhumane, they breed violence, as I discuss in greater detail below, and serve as a dangerous vector for the spread of disease.

21. My understanding is that the established standards for toilets and showers in correctional settings are based on infectious disease prevention requirements. Such precautions are necessary because disease spreads with dangerous speed in extremely [11] dense populations with limited sanitation facilities. According to the CDCR institutions chief, "[t]he overcrowding of CDCR facilities has led to increased numbers of infectious disease outbreaks . . . system-wide." Joint Pls' Trial Ex. 11 at ¶ 3

(Declaration of Scott Kernan in Support of Defendants' Report in Response to the Court's February 15, 2007 Order, May 16, 2007). The *Plata* Receiver has documented similar serious overcrowding-caused outbreaks, supporting his opinion that "[t]he serious levels of crowding in CDCR prisons and the unconstitutional levels of medical services" make it necessary to be alert to "the ever present danger of a serious infectious disease outbreak in California's prisons; a problem that not only jeopardizes inmates and staff, but also has an impact on public health in the community." Joint Pls' Trial Ex. 30 at 70-71 (Receiver's Fourth Bi-Monthly Report, March 19, 2007). As a correctional administrator, lam extremely concerned that lockdowns and limited programming also reduce access to exercise and fresh air; and increase idleness and frustration, with consequent negative effects on physical and mental health.

22. One result of having too many people and too few sanitary facilities are that toilets, lavatories, and showers will be used much more than originally contemplated and wear out faster. Prisoners complained of lack of hot water for weeks at a time at Avenal (on 5 Facility and Building 410, where prisoners complained that there had been no hot water for months) and for days at a time in CIM's West Facility. At San Quentin, staff noted that they could submit work order after work order to repair basic living unit [12] functions, hut the repairs were simply not done. As a result, staff expressed hopelessness and cynicism. At all three of these facilities, maintenance was inadequate and work orders were not addressed in a timely manner.

23. I saw everywhere evidence of crumbling infrastructure. Ventilation appeared to be inadequate at

CIM where I saw filters and screens that had clearly not been cleaned in quite some time. In Elm Hall, a housing unit that houses many paraplegics and other prisoners who use wheelchairs, all windows had been broken and were covered with plastic sheeting. Prisoners also complained that the roofs leak. At Avenal, I saw large amounts of mold in almost every shower that I inspected, demonstrating inadequate sanitation practices over a significant length of time.

24. One of the most dangerous effects of overcrowding on infrastructure lies in safety deficits. I saw a frightening range of fire hazards in the housing areas, where the very high population density exacerbates the risk of deadly fires. I saw few efforts to minimize this risk, but instead saw hazards such as flammable blankets and cardboard on cell doors and other flammable material in the cells and living areas. At San Quentin, the risk of fire disaster is unacceptable—there is no automatic cell unlock system, so in a fire emergency, each one of hundreds of cells, spread over five tiers in many living units, would have to be unlocked individually. It is simply impossible. On my tour of West Block, I smelled at two separate cell locations something burning. Clearly, prisoners are able to light flammable material in their cells, and are doing so if there were a fire in San [13] Quentin's cell blocks, many would die in their cells.

3. Staffing

25. Staffing as well as infrastructure is strained to the breaking point. At the same time as it experienced extraordinary inmate growth, the CDCR has substantially reduced the number of prison, staff, eliminating more than 5,000 workforce positions in the last 15 years alone. Joint Pls' Trial Ex. 4 at 125

(Reforming Corrections: Report of the Corrections Independent Review Panel, June 30, 2004). And the system has not even been able to fill the positions that remain: "CDCR projects current officer vacancies, statewide, at approximately 4,130. . . . [I]t will take about 5 years to fill, all of the vacancies under the current academy structure."[2] Joint Pls' Trial Ex. 43 at ¶ 14 (Declaration of Scott Keenan in Opposition to Writ of Mandate, *California Correctional Peace Officers' Organization v. Schwarzenegger*, No. 06CS01568 (Sacramento Superior Ct)., January 19, 2007).

26. CDCR staffing rates are already extremely low by national standards. According to Dr. Joan Petersilia, who has headed numerous CDCR reform research efforts, "[w]hile the nation's prisons average one correctional officer to every 4.5 inmates, the average California officer is responsible for 6.5 inmates. Although officer salaries are higher than average, their ranks are spread dangerously thin and there is a severe vacancy rate." Joint [14] Pls' Trial Ex. 5 at 2 (Dr. Joan. Petersilia, *Understanding California Corrections* (May 200(6)). The Receiver has expressed similar concerns about staffing: overcrowding "is accompanied by severe, staffing shortfalls" in clinical, custodial, and managerial staff. Joint Pls' Trial Ex, 26 at 11-13 (Receiver's Report Re Overcrowding). I agree with Dr. Petersilia and Mr. Sillen that the paucity of correctional officers in California, due to the low staffing rate and high number of vacancies, is

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[2] I saw no mention in Mr. Kernan's Declaration of how CDCR will account for the new vacancies that will come about if more prison beds are built as described in the declaration.

dangerous.[3] It is particularly dangerous for prisoners in need of medical care, as I discuss in Section II.A, below, not just because staff are not available to escort prisoners or clinicians to appointments, but because short-staffing can lead to forced overtime and burnout, such that staff make poor decisions, particularly in health care emergencies.

4. Management capabilities

27. Defendants themselves admit that the "rapid growth of the correctional system was not accompanied by organizational restructuring to meet increasing system demands and that it requires fundamental reform in a variety of areas, including management structure, information technology and health care services in order to function effectively and in compliance with basic constitutional standards." *Plata* Pls' Trial Ex. 1 at 4 (*Plata* Findings of Fact and Conclusions of Law Re Appointment of Receiver); *see also* Joint [15] Pls' Trial Ex. 4 at 1 (Deukmajian Report) ("the system's organizational structure has not kept pace with the massive growth in inmate population or with the vast geographical spread of the institutions,") As the Court has found, "[d]ecades of neglecting medical care while vastly expanding the size of the prison system has led to a state of institutional paralysis. The prison system is unable to function effectively and suffers a lack of

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[3] Several prisons I visited—notably CIM and Avenal—reported that they had no Vacancies, but the staffing patterns I observed were clearly inadequate to maintain security within an acceptable risk level and to address the needs of the prisoner population, especially in the housing units with "ugly beds." In fact, every institution I toured had inadequate custodial staff on the ground to address the needs of the prisoner population, including ensuring that health care services are provided.

will with respect to prisoner medical care." *Plata* Pls' Trial Ex. 1 at 2 (*Plata* Findings of Fact and Conclusions of Law Re Appointment of Receiver). Indeed, "[i]n the area of health care services, the consequences of system expansion without reform have been shocking." *Id*, at 5.

28. Overcrowding has yielded crisis decision-making as well as training and supervision deficits, which leads to poor decisions by line staff in the housing units, as discussed in. Sections I.B.3 and II.A. Further, the CDCR has inadequate information-gathering systems to properly run this enormous and complicated system, meaning that CDCR cannot adequately plan for, create, and manage specialized medical and mental health units and cannot perform the basic functions (such as background checks) necessary to hire the staff to carry out health care treatment and support services. *See* Joint Pls' Trial Ex. 26 at 12 (Receiver's Report Re Overcrowding). As the Receiver has noted, the computer network "that connects the 33 prisons, regional offices, and headquarters is well over 15 years old. It can currently support only email and very [16] limited data." Joint Pls' Trial Ex. 32 at 53 (Receiver's Sixth Quarterly Report). Moreover, there are multiple outages and system failures on a daily basis "that prevent its use as a system to house, access, and share clinical data," and the computers are not linked locally or between multiple prisons, "preventing the sharing of prisoner/patient health care data such as basic laboratory, pharmacy or other information that is essential .for patient safety." Sixth Report at 53.

29. The management failures are found at the very highest levels of state government. As I related above, I was prepared to witness troubling conditions

at the prisons I toured in California, hut was unprepared for the sheer magnitude of the crisis. I was even more appalled when I learned that California corrections and other state officials have known for many years that the problem was approaching emergency proportions. I have relied on the Governor's own State of Emergency Proclamation as an extraordinary admission of serious risk of harm for prisoners, staff, and the public, but I continue to be astounded that he issued it more than one year ago, and conditions have not improved.

30. It is indicative of the poor management that is apparent in this crisis that the Governor refused to see at least one of his corrections chiefs, Jeanne Woodford, when she attempted to meet with him regarding sentencing reform. Joint Pls' Trial Ex. 42 at 14:1-16 (Transcript of Proceedings, December 20, 2006, *Madrid v. Woodford*, No. C 90-3094 TEH). She was trying to see him because "our population pressures were just going to continue to become critical, and I felt that the only path to success had to include [17] sentencing reform . . . ." *Id.* at 11:10-15. In Texas, where we took prison population control very seriously, I had the governor's telephone number and met with him routinely every month. The personal contact with the highest level of management in state government was crucial to my ability to run a humane system.

5. Violence

31. One of the most pernicious effects of overcrowding is increasing levels of violence, and it is necessary to devote some discussion to the nature of these effects in order to better understand how overcrowding-driven violence and fear of violence interferes with medical and mental health care deli-

very. According to the CDCR, "overcrowding in CDCR prisons has . . . led to increased riots and disturbances." Joint Pls' Trial Ex. 11 at ¶ 3 (Declaration of Scott Kernan in. Support of Defendants' Report in Response to the Court's February 15, 2007 Order, May 16, 2007).

32. Overcrowding breeds violence in a number of ways. First, people are simply bumping up against each other far more often, especially those housed in triple bunks and dayrooms and hallways. They are also competing for extremely limited toilet, shower, and sink facilities and generate far more noise and smell in close quarters. Decades of experience have demonstrated to me that close physical proximity, lack of adequate supervision, noise, and competition for scarce resources are a recipe for violence in high-pressure prison settings. The lack of adequate toilets and sinks can also lead to long lines and anger at not getting basic needs met, which in turn can lead to violence.

[18] 33. Second, California prisoners have seen drastic cut-backs in the programming available to them due to the fact that programming space is used for warehousing bodies and because of the lockdowns due to staff limitations or violent outbursts. Joint Pls' Trial Ex. 6 at .22 (California State Auditor Report); Sections II.B and II.C, below. I observed on my tours that prisoners have inadequate out-of-cell time (or time spent outside of overcrowded dorms, gyms, dayrooms, and hallways) to compensate for the density of the population, especially at CIM, where prisoners living under extremely overcrowded, triple-bunked conditions had only a few hours per week of recreation in an exercise yard and few opportunities to obtain scarce prison jobs. The idleness and

hopelessness that accompany extremely limited programming in overcrowded living units breed frustration, anger, and violence. I agree with the Governors blue-ribbon panel that "combined with the reductions in security and non-security staff, the crowded conditions and lack of programming have elevated security risks and increased the probability of violent confrontations." Joint Pls.' Trial Ex. 4 at 125 (Deukmajian Report). I also agree with the *Coleman* Special Master that under overcrowded conditions, "[d]isturbances occur more frequently, with resulting increases in the number and duration of lockdowns." Joint Pls' Trial Ex. 35 at 7 (*Coleman* Special Master's Report Regarding Overcrowding, May 31, 2007).

34. Third, short-staffing and the use of "ugly beds" mean that staff has far less control over prisoners. It is far more difficult to supervise a gym densely populated with [19] triple-bunked minimum to maximum security prisoners, as at CIM East Facility, or a housing unit with people sleeping in bunk-beds in a hallway or dayroom, as at CIM and Valley State, than it is to supervise a unit where all prisoners are locked in cells. It is also far more difficult to get to know the prisoners in your unit when there are twice as many of them. These situations are very much a reality in CDCR. In CIM's West Facility, at Cleveland Hall, I saw 198 prisoners with only two officers to keep order, one in an office, with the other roving. Half of the dorm was in. another building connected by the shower/bathroom area, and one room in the back was completely out of sight. It is impossible to provide any type of security or proper services under these circumstances. The housing unit was a serious disturbance waiting to happen. If the prisoners wanted to take over the dorm they could do so in. a

second and no one would know. In the East Facility gymnasium at CIM that I toured, there were only two officers on duty at night and three during daytime watches, plus a gunner, to supervise 202 prisoners.

35. Visibility in these units was poor and sometimes sightlines were non-existent. The physical structure simply could not allow an acceptable level of security. Illicit activities would go on unnoticed and correctional officers are very much at risk. Further, these closed gyms and dormitories provide no opportunity for backup if radio communication is not available in an emergency, and the CDCR lacks adequate supervisory personnel and cameras that would augment the staffing. My review of the written materials and conversations with staff on the tours gives me confidence that these [20] conditions are replicated around the system — indeed, in many places, they are the norm.

36. With short-staffed and overworked officers, and angry, idle prisoners spilling out into common areas, experience tells me that not only is increased violence more likely,[4] but crisis decision-making based on the inadequate controls over the inmate population is guaranteed. The fear of violence and the potential for violence can have more immediate effects than violence itself, as officers make poor decisions, nearly invariably disbelieving prisoners and denying permission for movement, based on their concerns about controlling a population they perceive

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[4] Increased violence may not be reflected in statistics or in self-reports by prisoners, since, as I mentioned above, many illicit activities will take place out of the sight and knowledge of staff. It is impossible to measure fully the degree of violence, including sexual assaults, taking place among the prison population because there is inadequate staff supervision.

to be barely contained. Such decisions can have the effect of denying essential medical and mental health care, particularly in emergencies, as is discussed in more detail in Section II.A.2, below.

37. Not only does overcrowding cause violence, but violence also leads to even more overcrowding. California punishes prisoners who are found to have committed acts of violence in prisons with the removal of work-time credits, which results in longer terms, or by referring them to the district attorney for prosecution. *See* Cal. Code of Regs., tit. 15, §§ 1315, 1316, and 1323. Either way, the result is likely to be extended lengths of stay, which increases the population and ensures further deterioration of the system.

6. The overcrowding is getting worse

[21] 38. "The overcrowded conditions are projected to worsen over the next several years as the population continues to grow. Over the past 20 years, the state inmate population has grown at an average annual rate of 5 percent. If this trend continues, the LAO indicates that the state prison system will be deficient 152,900 beds by the year 2022." Joint Pls' Trial. Ex. 13 at 2 (Senate Budget and Fiscal Review Committee Subcommittee No. 4, Agenda of April 1, 2007). CDCR itself projects steady population increases, to 175,418 by June 30, 2008: 179,105 by June 30, 2009; 183,171 by June 30, 2010; 186,137 by June 30, 2011; 189,226 by June 30, 2012, and 191,886 by June 30, 2013. Joint Pls' Trial Ex. 19 at 2, 6 (CDCR Fall 2007 Adult Population Projections).

39. No relief is in sight. The CDCR itself projects that even if its population reduction strategies are implemented successfully, California's prisons will still hold 162,674 male prisoners in 2009 (compared

with 159,605 male prisoners today). *Plata* Pls' Trial Ex. 2 at 12 (*Plata* Defendants' Report in Response to the Court's February 15 Order, May 16, 2007); Joint Pls' Trial Ex. 25 at 1 (Weekly Report of Population, October 31, 2007). The state has no plans to lift the State of Emergency before 2009. Plata Pls' Trial Ex. 2 at 12. Under the recently passed prison-building law, Assembly Bill 900, not a single "in-fill" bed will be activated before 2009, assuming that defendants can meet their schedule, *Id.* at 9. There are already indications that they cannot, however.[5] AB [22] 900 also fails to include any plans for staffing. Joint Pls' Trial Ex. 13 at 8. Given how short-staffed the CDCR currently is, they will simply have no ability to open new beds because there will not he adequate staff to run the new housing units.

40. In summary, the overcrowding is pervasive and severe and, barring court intervention. conditions will continue to deteriorate.

C. By any definition, California's prison population exceeds its capacity to safely house prisoners and provide for their needs

41. Any discussion of overcrowding must be grounded in a common understanding of what constitutes prison population capacity. Many terms are used to define how many prisoners can be physically confined in an institution. In Texas, we measure

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[5] According to legislative experts, "the department's timeline for constructing the infill beds depends on its core business services functioning in a timely manner . . . [and] the majority of these functions within the department are not operating in a timely manner;" and "the remote location of many of the construction sites means that the department will likely have difficulty finding contractors willing to hid for the contract." Joint Pls' Trial. Ex. 13 at 7.

capacity by accounting for a wide range of factors that determine how many people can be held safely and humanely, grounded in all relevant accepted national standards and consistent with acceptable risk levels regarding violence and the spread of disease. *See* Appendix C, Texas Gov't Code §§ 499.101-110, 501.111-113. Specifically, an institution's capacity is meant to ensure that the system has enough space for safety, programming, and humane living conditions, as well as built-in extra space to allow routine maintenance shut-downs and the flexibility to transfer prisoners to specialized housing areas such as medical and [23] mental health units. Capacity includes the ability to provide "medical, dental, and psychiatric care adequate to ensure" minimal delays in service delivery as well as access to specialist care, "a sufficient number of psychiatric inpatient beds," and "sufficient staff" to "meet health care needs . . ." Texas Gov't Code. 499.102(a)(7), (8)(A)-(E). This definition is memorialized by statute, and each institution has a legally mandated capacity. *Id.* at § 499.101(a). This system ensures that the facilities and service areas—such as plumbing, kitchen space, electricity, laundry, education, etc.—are sized to the actual population, and not some anticipated or hoped-for number of prisoners. Our statutory system requires that the population may not exceed this statutory definition of capacity without the express permission of the Attorney General, and then only after rigorous "written findings that the population may be increased without limiting the ability of the division to transfer inmates between units and necessary for classification, medical, and security purposes" and approval of the governor. *Id.* at § 499.109.

42. Such a system is a distant dream in California, where by any measure, population vastly outstrips capacity. California's prisons are currently at 203.7 percent of "design" capacity, the determination by the prison architect as to how many prisoners an institution can hold, including how many toilets, lavatories, and showers are needed. Joint Pls' Trial Ex. 25 at 1 (Weekly Report of Population, October 31, 2007). In my experience, prison systems generally maintain their populations within design capacity. California's vast overflow, then, places it very far outside the range of accepted practice.

[24] 43. The design of some prisons makes them even more susceptible to overcrowding. For example, dorms are easier to overcrowd than cells. Avenal State Prison, which is nearly all dorm housing, was designed to hold 2920 prisoners. Joint Pls' Trial Ex. 25 at 2 (Weekly Population Report, October 31, 2007). At the time of my tour, staff informed me that it held approximately 7500, or 257 percent of design capacity.[6]

44. Another way of looking at prison capacity addresses the number of prisoners that can he held consistent with basic safety and security principles. California's population surpasses by 15,000 the "safe and reasonable" capacity, defined as "the maximum number of inmates who can safely and reasonably be housed in the prison system. . . . [The CDCR] has determined that the maximum safe and reasonable capacity of the state's male prisons is 137,764 – 179 percent of design capacity." Joint Pls' Trial Ex. 4 at

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[6] The impact on health care delivery of such overwhelming numbers is clear and damaging: prisoners in Building 550, a dorm that holds a large proportion of paraplegic and other disabled prisoners, reported that it takes six to eight weeks to see a doctor.

124 (Deukmajian Report). CDCR currently holds 153,759 male prisoners in California prisons. Joint Pis' Trial Ex. 25 at 2 (Weekly Report of Population; October 31, 2007).

45. "Operable" capacity comes closer to the Texas statutory definition, and "takes into account space needed for effective programming in addition to safety and security." Joint Pls' Trial Ex. 4 at 124 (Deukmajian Report). According to a "group of experienced California prison wardens," CDCR's "operable" capacity "to support full inmate programming in a safe and secure environment is 111,309 inmates, or 145 percent of [25] design capacity." *Id.* at 124). CDCR currently houses 171,285 prisoners in California, exceeding "operable" capacity by nearly 60,000. Joint Pls' Trial Ex. 25 at 1 (Weekly Report of Population, October 31, 2007).

46. Those definitions, however, still fail to look at the capability of a system or individual facility to adequately and. legally care for the medical and mental health needs of its population, considered an essential part of capacity in the Texas statutory scheme. A certain amount of clinical space with appropriate fixtures (such as for hand-washing, privacy, etc). as well as specific treatment beds for medical and mental health care needs that require isolation from the general population must be included in the design structure. California has chosen to design and build prisons with inadequate clinical space and medical/mental health beds for the projected population. According to the Receiver, the state's "newest and most modern prisons" were "designed with clinic space which is only one-half that necessary for the real-life capacity of the prisons." Joint Pls' Trial Ex.

26 at 19 (Receiver's Report on Overcrowding, May 15, 2007) (emphasis omitted).

47. For example, in building Kern Valley State Prison, the newest institution, "absolutely no consideration was given to the real life impact on the prison's health care program that would result by the CDCR's plans to immediately double cell the entire prison." *Id.* at 21. The prison "was planned, designed, and subsequently constructed knowing full well that the medical, mental health, and dental space and staffing would be entirely insufficient for the prison's actual population." *Id.* at 22. Similarly, prisoners in [26] acute mental health crisis situations are frequently housed in punitive administrative segregation conditions and other inappropriate, locations because of the shortage of mental health crisis beds (MHCBs), as the *Coleman* Special Master has documented. *See*, *e.g.*, Joint Pls' Trial Ex. 36 at 53 (18th Special Master's Report) ("[f]aced with a chronic shortage of MHCBs, [Mule Creek State Prison]. . . . used five cells in administrative segregation to monitor inmates waiting for MHCBs"); 184 (at Wasco State Prison, "Holding cells in the CTC, in B Facility chapel, or in administrative segregation were often used for inmates awaiting MHCB admission"); 250 (at R.J. Donovan, "the monitor's expert continued to find decompensating inmates in administrative segregation"); and 220 ("[t]wo inmates seen by the monitor's expert [at California State Prison at, Los Angeles County] were acutely mentally ill in administrative segregation for weeks rather .than being sent to higher levels of care"). This limiting factor further reduces the CDCR's capacity to house prisoners legally.

48. The different types of capacities discussed above address physical capabilities for housing

prisoners. Another definition of capacity involves available staff and services. For example, a fully equipped 1,000-bed prison cannot house 1,000 prisoners if only three staff members are available to run the institution. The prisoners cannot be fed or safely allowed out of their cells without adequate staff to supervise them, and cannot be provided appropriate medical and mental health care without clinical staff to care for them and custodial staff to escort them to and from appointments both inside the prison [27] and to specialists outside, as well as providing security during their appointments.

49. Over the last several decades, California has made deliberate choices regarding how to house its massively expanding population, building, huge prison complexes mostly in isolated rural areas. It is harder to recruit staff to come to such locations, particularly clinical staff. Joint Pls' Trial Ex. 26 at 14 (Receiver's Report on Overcrowding, May 15, 2007). Custodial staff shortages have also plagued the CDCR for many years, as described above in Section I.B.3. As of October 31, 2007, 10 prisons exceeded what the CDCR determines to be their "staffed capacity": California Men's Colony, Corcoran, California State Prison Los Angeles County, San Quentin, Correctional Training Facility, Deuel Vocational Institution, Folsom State Prison, Kern Valley State Prison, Sierra Conservation Center, and Wasco. Joint Pls' Trial Ex. 25 at 2 (Weekly Report of Population, October 31, 2007).

50. Thus, any measure of California's prison capacity that includes a reasonable expectation of providing constitutional levels of medical and mental health must account for the severely limiting building design and staffing needs. As the Receiver has reported, "overcrowding is ingrained in the CDCR

style of constructing and managing prisons. Crowding related policies that do not provide adequate clinical and program space are now an accepted practice of CDCR prison planning, as is California's practice of offering inadequate salaries and failing to provide adequate hiring programs which have created crisis levels of shortages of clinical personnel and correctional officers." [28] Joint Pls' Trial Ex. 26 at 8 (Receiver's Report on Overcrowding, May 15, 2007).

51. The Governor's blue-ribbon panel declared more than three years ago that "California's prisons are presently filled to the breaking point, with populations exceeding both design capacity and 'safe and reasonable capacity,' and far exceeding operable capacity." Joint Pls' Trial Ex. 4 at 124 (Deukmajian Report). At that time, the population was 162,000. *Id.* at 1. Today, CDCR houses nearly 10,000 more Joint Pls' Trial Ex. 25 at 1. (Weekly Report on Population, October 31, 2007). The situation looks even more dire when all of the factors that we in Texas consider essential components of capacity are considered, and California's severe deficits in building design and staffing capabilities are factored into the equation. I wholeheartedly agree with the statement the Governor made more than a year ago: California' prison population "exceeds the capabilities of the services, personnel, equipment, and facilities of any geographical area in this state," causing "extreme peril." Joint Pls' Trial Ex. 1 at 8 (Governor's Emergency Proclamation). The "extreme peril" in the potential for violence is easy to see. Less obvious is the "extreme peril" of teeming populations of prisoners, at risk for deadly disease outbreaks and overwhelming through sheer numbers any attempt to provide even the basics of humane medical and mental health care, as discussed in Section II.

II. Overcrowding makes the custodial management necessary for medical and mental health care nearly impossible

52. Custodial staff and managers play an essential role in medical and mental health care. Although non-clinicians are not directly responsible for providing health care, in a [29] well-functioning system they establish and run the supporting structure that makes health care delivery possible. They provide escorts and security that allow medical appointments to occur. They staff and run specialized health care units. They transport offenders to specialty medical appointments off site. They are usually the first to respond in any medical and mental health emergency. They see the prisoners on a daily basis and often serve as the gatekeepers that allow them to access care providers. They classify and place prisoners in appropriate housing units for their medical and mental health needs. In California, the short-staffing, inadequate management and supervision, and crisis conditions caused by overcrowding have made it nearly impossible for custodial staff to carry out these, essential medical support roles.

A. Staffing

53 Custodial staff plays several essential roles in the delivery of medical and mental health care in California prisons. They serve as escorts for medical appointments; they respond in health care emergencies; and as the staff with most interactions with the prisoner population, they become de facto watchdogs and gatekeepers for health care delivery.

1. Escorts

54. Staff is needed to move prisoners around within the prisons for medical appointments and outside the

prisons for tests, specialist consultations, and emergency treatment. They are also needed for security during examinations. In California's [30] overcrowded system, staff is often not available, for transportation within and outside the prisons. CDCR's head of adult institutions admits as much: "These riots deflect prison. resources so that while correctional officers now must respond to the increased security concerns and maintain watch over an increasingly dangerous prison population, they are not able to assist the Receiver's efforts in addressing the inmates' medical concerns by escorting inmates to medical appointments, for instance." Joint Pls' Trial Ex. 11 at ¶ 3 (Declaration of Scott Kernan. in Support of Defendants' Report in Response to the Court's February 15, 2007 Order, May 16, 2007). As the Court has already found, "[c]orrectional officers often are not available to take prisoners to medical appointments or to enable the physicians to do examinations. . . ." Plata Pls' Trial Ex. 1 at 22 (*Plata* Findings of Fact and Conclusions of Law Re Appointment of Receiver) (citation omitted)

55. The *Coleman* Special Master has made extensive findings that the paucity of escorts has interfered with mental health treatment. *See*, *e.g.*, Joint Pls' Trial. Ex. 36 at 72 (18th Special Master's Report) (in the California Medical Facility's administrative segregation, "[r]oughly three dozen [mentally ill] inmates did not have confidential meetings due to lack of space, escorts, and schedules"); 84 (at the California State Prison at Solano, "[m]odified programming and failure to honor priority ducats for mental health contacts stymied access to treatment on the level III yards, where modified programming was in force throughout 2006 save for a few weeks. No escorts were available for mental health appoint-

ments"); 103 (at Deuel Vocational Institution, "[a]n audit in October 2006 [31] found that 68 percent of case manager contacts were cell-front due to lack of space and escorts"); 115 (at Corcoran, "[p]rovision of mental health treatment to [mentally ill] inmates in administrative segregation was fraught with difficulty . . . Treatment space, escorts, and confidentiality were problematic"); 168 (at the Correctional Training Facility, [o]bstacles to confidential out-of-cell [case manager] contacts included escorts and space"); 227 (at California Correctional institution, "[t]ime, escort availability, and space constraints stymied meaningful clinical contacts with [mentally ill] inmates in high-security units"); and 254 (at R.J. Donovan Correctional Facility's administrative segregation unit, "[h]alf of all completed [clinical] contacts occurred at cell-front due to a combination of high caseloads, inadequate escort support, and an insufficient number of holding cells").

56. In another example, the California Rehabilitation Center recently converted from ,a mixed population of men and women to all-male, necessitating a move of approximately 600 women to different institutions. *Id.* at 5. As a result, one of the receiving institutions was "overwhelmed with the influx of inmates and custody has closed down some of the off site transportation which is now causing a delay in care." *Id.* at 6 & Exh. 3. According to staff at the receiving prison, "they were at 200% of capacity and . . . there were inmates on the floors. She [the Health Care Manager] does not know how she is going to deliver care to these inmates." *Id.*

57. At San Quentin four very diverse groups of offenders are housed in the Badger [32] cell housing area of the South Block. These four groups consist of

reception offenders, gang members, protective custody offenders, and offenders doing life terms. Because these groups cannot mix with each other the custodial staff must handle services to each group at a distinctly separate time. Staff admits that they struggle daily and sometime fail to meet the service demands of these four sub-populations that all reside in the same cell housing area.

2. Emergency response

58 Custodial staff also performs certain necessary functions within medical housing units, such as responding to "man down" or emergency calls. With chronic short-staffing, these functions sometimes are not performed, with consequent dangers to the prisoner population. For example, the Court has already found that "[i]n medical units that lack call buttons for prisoners to contact doctors, custody staff routinely fail to make rounds and check on patients." *Plata* Pls' Trial Ex. 1 at 22 (Findings of Fact and Conclusions of Law Re Appointment of Receiver).

59. Overcrowding has also interfered with the ability of staff in regular housing units to respond appropriately to urgent and emergent medical and mental health situations. I know from experience that overworked staff without adequate back-up are less able to respond to emergencies and more likely to downplay prisoners' concerns. In a housing unit such as San Quentin's H Unit Dorm 2 (one officer for 200 prisoners) or CIM's West Facility Cleveland Hall (two officers for 198 prisoners) or East Facility gym (two officers [33] for 202 prisoners), staff in an emergency can only sound the alarm, make frantic telephone or radio calls, and hope for backup. An officer alone with several hundred inmates is unlikely, for example to perform emergency first aid or CPR—it is simply

unsafe to do so with no backup, when prisoners could easily simulate an emergency as a diversion. This inability to perform basic lifesaving functions could have potentially devastating consequences on the life and health of a prisoner undergoing a medical or mental health emergency. This situation presents an unacceptable risk of harm to prisoners.

3. Watchdogs and gatekeepers

60. Custodial staff in the housing units generally has more contacts with prisoners than any other staff. They release prisoners for appointments and meals and are generally responsible for overseeing the delivery, of their basic needs. A housing unit officer does not provide mental health care, but if a prisoner is decompensating, that officer is in the best position to see what is happening, recognize the problem, bring in the clinicians to address the patient's mental health needs, and ensure that he does not harm himself or others. Similarly, a housing unit officer does not provide medical care, but if a prisoner does not emerge for multiple meals in a row, that officer is responsible for recognizing the potential danger and investigating to ensure that the prisoner is not sick, or incapable of meeting his own needs. Under overcrowded conditions, with short-staffed units, and line officers who are overwhelmed and even fearful, they are far less likely to recognize a [34] prisoner in need of services and perform this essential function. In addition, managers are overwhelmed, and line staffs often do not get the attention and direction needed to run a safe, humane operation.

61. Short-staffing: places managers and line staff alike in unacceptable positions. As the Receiver has noted, "[m]any CDCR prisons are unable to sustain

the basic delivery of medical, mental health, and dental services because of limited staffing (clinical and custody) and an overwhelming number of prisoner/patients who require care. Every day, many California prison wardens and health, care managers make the difficult decision as to which of the class actions, *Coleman*, *Perez*, *Armstrong*, or *Plata* they will fail to comply with because of staff shortages and patient loads." Joint Pls' Trial Ex. 26 at 30 (Receiver's Report on Overcrowding). I agree, and I observed this phenomenon on my prison visits. For example, at San Quentin and CIM, two Reception Centers where prisoners must be escorted to meals, yard, laundry, and other basic functions, staff by their own report get "maxed out" and unable to fulfill the needs of prisoners and the legal requirements of their jobs. Medical and mental health care are included in this burn-out, and demoralized staff often make poor decisions.

62. In. an atmosphere of crisis where all operations other than essential safety and security moves are shut down, medical and mental health care are lower and lower priorities. Prison staff is less likely to know the prisoners in their units and have the time, the ability, and the willingness to identify and respond appropriately to basic medical and [35] mental health needs.

B. Lockdowns

63 Overcrowding engenders a state of perpetual crisis that shuts down non-emergency prison functions. I agree with the Governor's expert panel: "Staffing reductions, overcrowding, and attendant violence have eroded the ability of the prisons to operate effectively for any purpose other than security." Joint Pls' Trial Ex. 4 at 125 (Deukmajian Report). Riots and, distur-

bances at Avenal, the California Correctional Center, Calipatria, and Wasco alone account for thousands of days on lockdown or modified programs. Joint Pls' Trial Ex. 11 at ¶ 3 (Declaration of Scott Kernan. in Support of Defendants' Report in Response to the Court's February 15, 2007 Order, May 16, 2007). The Governor noted more than a year ago that overcrowding has "substantially limited or restricted. inmate movement . . ." Joint Pls' Trial Ex. 1 at 6 (Emergency Proclamation).

64. Lockdowns impact health care delivery because they "call for a radically different form of medical delivery than the services provided under normal general population conditions"; when, non-essential movement is shut down, "clinical staff must go from cell to cell to see the prisoner/patient, or small groups o[f] individual prisoners must he escorted by correctional officers to and from clinic areas," so that lockdowns "inhibit the delivery of medical care and increase the staffing necessary for such care." Joint Pl's Trial Ex. 26 at 29-30 (Receiver's Report Re Overcrowding). Lockdowns are also [36] isolating, keeping prisoners in their cells or bed areas and making it harder to get staff attention during health care emergencies and harder for custodial staff to notice prisoners' medical and/or mental deterioration.

65. As a result of lockdowns, many prisoners spend extreme amounts of time in their cells or crowded dorms or gyms, with drastically limited time in beneficial programs or basic living needs, The Coleman Special Master has documented extensively the ways in which lockdowns and partial lockdowns ("modified programming") injure prisoners with mental illness by denying them needed mental health care. Joint. Pls' Trial Ex. 36 (18th Special Master's Report) at 40

("[group therapy was available on all four yards at [High Desert State Prison], though institutional lockdowns and program restrictions caused frequent cancellations and limited inmate participation"); 84-85 (at the California State Prison at Solana, "[m]odified programming and failure to honor priority ducats for mental health contacts stymied access to treatment on level III yards, where modified programming was in force throughout 2006 save for a few weeks. No escorts were available for mental health appointments"; in addition, "rising caseloads, poor access to treatment associated with prolonged modified programming in, one yard, and ducat problems forced clinicians to resort too often to quarterly visits that were little more than a cursory check-in, many of which occurred at cell-front or in locations that compromised visual or auditory privacy. Under these conditions, a subset of sick inmates got sicker, and clinicians sometimes missed, or failed to respond appropriately to, signs of mental [37] illness"); 208 (California State Prison-Los Angeles County's "administration reported that lockdowns in November 2006 and January 2007 disrupted [mental health] treatment,"); and 288 (California Institution for Women's treatment unit for seriously mentally ill patients "continued to limp along.. Although over ten hours of groups per inmate per week were scheduled; inmates received only two to three hours of treatment per week. Staff audits found that 46 percent of groups were cancelled. . . . Lockdowns and other forms of restricted inmate movement were the largest single cause of cancellations").

66. I agree with the Receiver that [o]vercrowding has resulted in increasing numbers of prisoner disturbances and [l]ockdowns' by prison authorities in response. Because of the heightened security

measures associated with lockdowns, medical care to the inmates is delayed and made substantially more time-consuming and cumbersome." Joint Pls' Trial Ex. 27 at 3 (Receiver's Supplemental Report Re Overcrowding, June 11, 2007).

C. Classification

67 Overcrowding has pernicious effects on classification, the central organizing principal that keeps modern prisons as safe as possible for prisoners and staff by separating More dangerous inmates from more vulnerable prisoners and concentrating those in need of intensive medical and mental health treatment in places where services are more readily available and custodial as well as treatment staff are better trained to meet their needs. In a proper classification system, prisoners are assigned an objective classification score based on a range of weighted factors intended to predict their [38] institutional risk and specialized needs. Overcrowding has wreaked havoc with CDCR's classification systems intended to maintain safe conditions and ensure appropriate specialized health care placement.

68. Overcrowding leads to classification failures that impact medical and mental health care delivery in two ways. First, the overburdened system no longer houses prisoners according to their classification levels in an alarming percentage of cases, making it harder to provide for their medical and mental health care needs, and second, the overcrowded system does not have the flexibility needed to respond to inevitable crises.

69. In any well-functioning classification system, "overrides," or instances in which staff make a reasoned determination that a prisoner is more

appropriately housed in a different location than his classification score would indicate, should be no more than 10% In California's overcrowded prisons, an estimated 25% of prisoners are housed outside of their security levels, many in higher security housing. Joint Pls' Trial Ex. 5 at 14 (Dr. Joan Petersilia, *Understanding California Corrections*). The most common reason to override classification scores in California is called a "population override," which "occurs when no bed is available at the type of facility that would normally be used for an inmate with a given score. Under those circumstances, the classification staff representative has total discretion over prisoner placement. This override has become increasingly common as California prisons have filled up beyond their designed capacity [39] [], and this shuffling of inmates to areas that were not designed to hold them has adverse consequences for both the facilities and the individuals they house." *Id.* (footnote omitted). In fact, this is not an override at all—this is the rejection of any classification scheme, at all for these estimated 25% of prisoners. In any event, it is two and an half times greater than the accepted norm for variations from the classification scheme, and presents an unacceptable risk of violence and harm. As Dr. Petersilia notes,

> There are significant implications of these frequent reassignments to more heavily fortified facilities, where inmate violence is higher, [citation omitted] the housing cost per-prisoner is higher, and a lower level of programming is available to inmates. In other words, the pressures of overcrowding frequently lead to housing assignments that are more expensive and dangerous than necessary and less likely to encourage rehabilitation . . . .

> [¶] . . . Prisoners in a maximum-security prison or unit spend a good part of the day in their cell, have strictly regulated movement, and are surrounded by a secure perimeter with extensive gun coverage. At the other extreme, in a minimum-security, conservation camp, prisoners spend a large part of the day out of their dorm and have few restrictions on movement within an unfenced security or work area. [citation omitted] These variations in inmates' level of movement translate into tremendous differences in their ability to participate in rehabilitation programs."

Id.

70. I saw these problems in practice at Avenal, where Building 510 houses 300 prisoners; the population overflow goes to segregation units intended for punitive purposes, where they are treated like segregation prisoners. Similarly, prisoners suffering acute mental health crises are often housed in punitive administrative segregation conditions because of the shortage of mental health crisis beds, as noted in Section I.C, [40] above.

71. The widespread rejection of CDCR's classification system has a significant impact on medical and mental health care: it is harder to get to health care appointments within the prison as well as out-of-prison specialty appointments, and more limited staff contact means that staff are less responsive to emergencies due to distrust, lack of understanding and compassion, and simple logistics: it is harder to get staff attention in a high-pressure, high-security unit. In addition, prisoners are subject to increased degrees of danger and potential for violence because they are placed with more dangerous and violent

prisoners than their classification scores would warrant.

72. Mixing prisoners of different security levels and different needs is also extremely dangerous. At CIM, I saw prisoners of all security levels, minimum to maximum, in a Reception Center dorm setting, and at Valley State Prison for Women, I saw a dayroom which had double bunks for Reception Center prisoners. That kind of configuration is unacceptable for prisoners who have not been classified, about whom staff know little or nothing. At CIM, staff in West Facility admitted that maximum security (Level IV) prisoners are in the yards along with minimum security (Level I and II) prisoners. At San Quentin, on West Block and in the Badger Unit of South Block, I saw gang members on one tier, protective custody on another, general population on another, and prisoners serving life terms on yet another. Having all of these very different, often directly opposing needs in one housing unit makes it extremely difficult to meet all of their needs, [41] since gang and protective custody prisoners cannot come into contact with one another, for example, necessitating, separate yard and feeding periods. Health care appointments are thus even more difficult to facilitate than would he the case in a short-staffed and overcrowded housing unit that nonetheless housed prisoners with uniform classification levels.

73. The second overcrowding-driven classification failure comes about because classification systems need built-in flexibility to respond to unforeseen needs. That is why, for example, in Texas we have defined "capacity" to include enough space to ensure "proper inmate classification and housing within the unit that is consistent with the classification system" as

well as "housing flexibility to allow necessary repairs and routine and preventive maintenance to be performed without compromising the classification system . . ." Texas Gov't Code § 499.102(a)(1)-(2) (Appendix C).

74. This level of flexibility is impossible with the current violence and state of crisis in California's prisons. For example, in late 2006, Los Angeles County cancelled a long-standing contract with CDCR for 1300 beds, requiring that the beds be vacated by January 31, 2007. According to CDCR's Director of CDCR Division of Correctional Health Care Services, this action would result in "thousands of inmate moves over a 13-week period scheduled to begin in September 2006." Joint Pls' Trial Ex. 54 at 1 (Dr. Peter Farber-Szekrenyi, letter to *Plata* Receiver Robert Sillen and *Coleman* Special Master J. Michael Keating, Jr., September 1, 2006).

[42] 75. CDCR simply did not have the capacity to deal with this event in an appropriate way and instead was forced to resort to cutting legally required corners. The head of medical services admitted that during the resulting transfers, CDCR would be unable to comply with legal requirements such as transferring prisoners with a 30-day supply of prescribed medications, performing intake assessments and tuberculosis tests on new arrivals, and completing medical summary forms for transferring prisoners. *Id.* at 2-3. Other "necessary medical services" would suffer "increased delay": outside specialty service appointments would he cancelled for prisoners scheduled to transfer. *Id.* at 3. Further, in order to conduct "required [mental health] evaluations, the existing mental health staff w[ould] have to be

redirected from their primary responsibility of direct patient care." *Id*. at 2.

D. Management systems

76. Overcrowding has overburdened CDCR's inadequate management systems that underlie health care delivery. The excessive population leads to management failures in two ways. First, overcrowding engenders a state of perpetual crisis that causes management failures. Administrators spend their time doing damage control, rather than making sure the prison is operating properly and prisoners are getting the services that they need. I was the warden of a prison with 3,000 prisoners and that was almost unmanageable. A population of 7,000 or more, as is found in some California prisons, is not manageable at all. The sheer size and complexities of managing a prison, that size [43] would be overwhelming, for one manager especially with the limited resources in the areas of staffing and inadequate space for services to the offenders that I observed at all of the prisons I toured in California. One warden simply cannot know what he/she needs to know on a daily basis to make good informed management decisions.

77. Second, overcrowding overwhelms management infrastructure. As I have read in numerous reports of the Receiver, the CDCR lacks the management information systems needed to adequately organize and track prisoner transfers for specialized medical and mental health care and public health related needs (for example, people with compromised immune systems not going to Valley Fever risk areas) in the severely overcrowded conditions. Joint Pls' Trial Ex. 32 at 53 (Receiver's Sixth Quarterly Report). *See* discussion at I.B.4, above. CDCR also fails to hire

adequate numbers of custodial as well as medical staff. *See* Joint Pls' Trial Ex. 26 at 11-12 (Receiver's Report Re Overcrowding).

78. CDCR also cannot track and transfer essential health care records, because the record system lacks the capacity to deliver records regarding this many prisoners. I was told at CIM that 98% of parole violators do not have their files when they arrive, which leads to security problems because staff are unable to properly classify prisoners. As I saw on my tours, staff is failing utterly in the essential task of maintaining health care records. Adequate record-keeping is a basic component of correctional systems management, but at Avenal, a prison I was told was built for 2900 prisoners with a [44] current population of 7500. I was told that there was four feet of loose filing waiting to be placed in prisoners health records. At QM, I saw 48 inches of unfiled documents plus two additional cardboard boxes of unfiled medical records that had just arrived. Staff told me they had 54 inches several days earlier and has been much higher at other times. I am not surprised; given the extraordinary number of prisoners in these facilities, it is simply impossible to manually file so many records on a timely basis. In my experience, such extraordinary pressure on staff also leads to serious filing errors, which means that even records that have been filed might not be available to clinicians, and might be impossible ever to locate.

79. In sum, it is impossible under current conditions to provide adequate medical and mental health care to California prisoners.

III. Overcrowding is the primary cause of the constitutional violations

80. Based on the above, my opinion is that overcrowding is the primary cause of the medical and mental health constitutional violations caused by deficiencies in the support role played by non-health care staff. In rendering this opinion, I agree with the Governor's blue-ribbon panel of experts that "[t]he key to reforming the system lies in reducing the numbers." Joint Pls' Trial Ex. 4 at 3 (Deukmajian Report). I also agree with the *Plata* Receiver, when he reports that "[m]ost California prisons operate at 200% of capacity, with no effective relief in sight. Unless and until the living conditions of some prisons and the overpopulation experienced system-wide is effectively addressed, the [45] Receiver will be impeded in applying systemic an even some ad hoc remedies to the medical care system." Joint Pls' Trial 53 at 3 Receiver's First Bi-Monthly Report, July 5, 2006). I further agree with the California State Auditor that "[m]eeting the constitutional rights of inmates to receive minimum standards of treatment" is a problem that "emerge[s]" from overcrowding. Joint Pls Trial Ex. 6 at 22-23 (California State Auditor's Report). I also agree with the Office of the Inspector General that efforts to solve the medical care failures "are severely hampered by inmate population pressures that have prisons straining at nearly twice design opacity, spreading staff resources thin and leaving little facility space available for programming and other purposes. Developing sustainable solutions will require the [CDCR], state policymakers, and the public to collectively address the available options' to reduce overcrowding, Joint Pls' Trial Ex. 46 at ES-1 (Office of the Inspector General, Accountability Audit, Review of the Audits

of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs, 2000-2004, April 2006).

Date: November 9, 2007

/s/ Doyle Wayne Scott
Doyle Wayne Scott

[Filed 10/30/08]

[1] THIRD SUPPLEMENTAL EXPERT REPORT OF RONALD SHANSKY, M.D.

SEPTEMBER 28, 2008

1. I make this third Supplemental Report after reviewing the Receiver's Ninth Quarterly Report, filed September 15, 2008.

2. My opinions as stated in my previous reports remain unchanged. Certain of those opinions are further supported by matters included in the Receiver's Ninth Report.

3. Overcrowding delays the time-frame in which the CDCR medical care delivery system will be able adequately respond to the serious medical needs of its prisoners. The Ninth Report discusses problems identified and remedial efforts found necessary following the death of a California prisoner transferred to an out-of-state facility, and the impact of that incident on in-state remedial efforts. Ninth Report at pages 48-49. Addressing that matter "had a serious negative impact on the office of the Receiver, drawing clinical personnel away f[ro]m other important projects and delaying 'in-state' remedial efforts. In essence, thousands of dollars of valuable clinical hours have been devoted to helping a private prison . . . rework its medical delivery system . . . in order to keep the out of state transfer process from collapsing. In fact, the in state remedial process has suffered as a result." *Id.* at page 49. This is an example of how population pressures and addressing overcrowding interfere with and detract from efforts to improve medical care.

4. The Receiver reports that the prisoner death rate in California has been trending downward for

the last ten quarters. Ninth Report at pages 68-70. This is an [2] encouraging development. Discussing this development, the Receiver emphasizes that, "a constitutionally adequate and sustainable prison medical system will not be established until the Turnaround Plan of Action is fully implemented." *Id.* at pages 69-70, I. agree, and the inadequate system will continue to exist for longer than it otherwise would unless there is a significant reduction in the population.

Dated: September 28, 2008

/s/ Ronald Shansky,
Ronald Shansky, M.D.

SECOND SUPPLEMENTAL EXPERT REPORT OF RONALD M. SHANSKY, M.D.

SEPTEMBER 10, 2008

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[1] SECOND SUPPLEMENTAL EXPERT REPORT OF RONALD M. SHANSKY, M.D.

I. EXPERT QUALIFICATIONS

1. I am a Physician Consultant specializing in correctional medicine and continuous quality improvement, and a voluntary attending physician for the Cook County Hospital, Department of Medicine, in Chicago, Illinois. My C.V. is attached.

2. I have provided two prior reports in this matter, on November 9, 2007 and on December 6, 2007. My November report sets forth my complete academic and professional career.

3. I have listed all of my publications on my attached C.V. I have not published additional publications since my November 2007 report.

4. I am billing the plaintiffs $250 an hour, my usual billing rate. For testimony, my rate is $350 an hour. I have not testified in any cases since November 9, 2007.

II. BASES FOR EXPERT OPINIONS

5. I have been retained by plaintiffs' counsel in the *Plata* and *Coleman* cases as an expert in prison medical care and health care administration, and the impact of overcrowding on prisoners' medical care, including how prison overcrowding detrimentally affects prisoners' access to health care and interferes with the ability of prison officials to meet the existing and increased medical needs of the prisoners in an overcrowded system. I have also been asked to render my opinion with respect to whether overcrowding in the California Department of [2] Corrections and Rehabilitation (CDCR) is the primary cause of the current unconstitutional conditions experienced by

members of the Coleman and Plata classes. My opinions are based upon the evidence that I have reviewed to date documenting current conditions within the CDCR, on my earlier inspections of California Institution for Men (CIM), Avenal State Prison (ASP), Valley State Prison for Women (VSPW), San Quentin State Prison (SQ) and High Desert State Prison (HDSP), on my more recent inspections of North Kern State Prison (NSKP), the Substance Abuse and Treatment Facility at Corcoran (SATF), Pleasant Valley State Prison (PVSP), California State Prison at Solana (SOL), and a second inspection of HDSP, and on my professional experiences working in similarly overcrowded correctional settings. A list of the documents I have reviewed is attached.

6. During my inspections, I spoke to medical staff throughout the facilities, including the Health Care Managers, Chief Medical Officers, physicians, nurses and schedulers. The staff members at each prison were consistently cooperative, provided me with the files, logbooks, documents, records and data I requested, and ensured my full access to the facilities I wished to inspect.

7. In my first report, I concluded that the CDCR's medical delivery system was operating in a state of crisis that harmed prisoners with serious medical concerns and placed them at substantial risk of harm because the number of prisoners in the system far outstripped the capacity of the system to provide care. Having completed the five recent prison inspections and reviewed recent documents, including the Receiver's Seventh and Eighth Reports and his Turnaround Plan of Action, my opinion is unchanged: the CDCR's medical care [3] delivery system cannot provide a constitutional level of care because the

prison system incarcerates far more prisoners than can be adequately treated with the resources, staffing and facilities available in the CDCR. In short, it is my opinion that overcrowding is the primary cause of the constitutional violations in the CDCR for *Plata* class members.

8. I also concluded in my first report that it will not be possible to achieve a constitutional level of health care in the CDCR in the foreseeable future, unless the prison population is significantly reduced. My opinion has not changed. The limitations on the CDCR, including staffing, administrative resources and especially treatment space, are so severe that the only avenue for building a constitutional health care delivery system is to reduce the demand on the system by lowering the number of patients it serves.

9. While I believe that reducing the population is necessary to achieve a constitutional level of medical care, population reduction alone will not, in a vacuum, produce a constitutionally adequate medical delivery system. For example, if the population were reduced at a prison facility, but that prison lacked sufficient numbers of physicians, the care would still be unconstitutional. Reducing overcrowding is not a panacea, but crowding is the primary cause of the ongoing inadequate medical care in the CDCR system. Overcrowding is the one factor that negatively impacts almost every other matter that must be addressed to create a minimally adequate medical care delivery system for California's prisons.

10. Reducing the population in the system to a manageable level is the only way to create an environment in which other reform efforts, including strengthening medical management, hiring additional medical and custody [4] staffing, and improv-

ing medical records and tracking systems, can take root in the foreseeable future. Continuing efforts to build a constitutional system under the current overcrowded conditions will guarantee that the unconstitutional conditions, and preventable suffering, will exist for a substantially longer period of time than would be the case if the population were reduced.

11. The Receiver has tools to fix the health care system, but has no tool within his purview, to deal with external pressures such as overcrowding. The Receiver's mandate is to remove the Court's direct control of the CDCR health care delivery system as quickly as possible. It is my opinion that, if the current overcrowding is not remedied, the Court's involvement in overseeing the health care system will certainly extend many years.

III. EACH OF THE PRISONS I INSPECTED IN AUGUST, 2008 IS DRAMATICALLY OVERCROWDED.

12. According to the CDCR's August 20, 2008 population statistics, there were 159,823 prisoners housed in CDCR prisons and camps, which is 191 % over the prison system's design capacity. Jt. Pls' Trial Ex. 98. The five prisons that I inspected are all, like the system itself, significantly overcrowded, and at some prisons, the higher security classification prisoners are the most significantly overcrowded. All five of the prisons currently house prisoners in "non-traditional" beds, including bunks in gyms and day rooms that were not designed for housing.

13. North Kern State Prison was built for 2,694 prisoners. Id. As of August 20, 2008, the prison was at 204% capacity, housing 5,496 prisoners. *Id.* Most

NKSP prisoners, over 4,600, are housed in the Reception Center. *Id.* The remainder of the population is made up of 297 Level I prisoners and 581 Level III prisoners. *Id.* NKSP also serves as a health care "hub" for an additional 2,000 [5] prisoners housed in community corrections facilities who receive health care at the prison.

14. The Substance Abuse Treatment Facility and Prison at Corcoran was designed to hold 3,424 prisoners, but the total population as of August 20 was 7,121, *i.e.*, 208% of design capacity. *Id.*

15. Pleasant Valley State Prison, built for 2,308 prisoners, now houses 5,199, making it among the state's most overcrowded prisons at 225% of design capacity. *Id.* That prison houses primarily Level III and IV prisoners (over 4,900), and has a small minimum security facility (MSF) housing fewer than 300 Level I and II prisoners. *Id.* While the MSF is less crowded than most other facilities, at 131% of design capacity, the Level III/IV facilities are currently at 234% of design capacity. *Id.* The prison staff also provides care to prisoners at a community care facility with approximately 400-500 patients.

16. California State Prison, Solano, with 5,607 Level II and Level III prisoners in space designed for 2,610, is at 214% capacity. *Id*, The Level III prisoners are slightly more crowded than the Level II prisoners, with rates of 225% and 206% respectively. *Id.*

17. High Desert State Prison has 4,472 prisoners in a prison built for 2,324. *Id.* With fewer than 1,000 Level I, II and III prisoners, the majority of the prisoners are either Level IV (approximately 2,850) or in the Reception Center (approximately 640). *Id.* Both of these populations are very overcrowded: the

Level IV prisoners are housed at 253% of design capacity, and the Reception Center prisoners are housed at 319% of design capacity. *Id.*

[6] IV. THE PRISON HEALTH CARE FACILITIES STILL ARE INADEQUATE FOR THE NUMBER OF PRISONERS WHO REQUIRE MEDICAL CARE.

18. The Receiver recognized the critical shortage of health care facilities in his Turnaround Plan of Action,

> The facilities available for providing health care services within CDCR are woefully inadequate. . . . We are dealing not with deferred maintenance, but with some facilities that are literally falling apart. In addition, investments in health care facilities have significantly lagged behind growing inmate populations, so much so that available clinical space is less than half of what is necessary for daily operations.

Jt. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report, Exh. I—Receiver's Turnaround Plan of Action) at 25. Based on my site inspections and review of documents, I believe the Receiver accurately describes the critical shortage of adequate clinical space for the existing prison population. These conditions, which are also described in my first report, create insurmountable barriers to providing timely medical care with appropriate confidentiality safeguards. Additionally, I believe that the lack of clinical and medical office space creates an unprofessional working atmosphere that likely impedes CDCR's recruitment and retention efforts.

19. The Receiver's Turnaround Plan includes plans to build and upgrade clinical spaces around the state.

I understand, however, that the Receiver has yet to obtain funding for this construction plan, and has recently had to move to hold the Governor in contempt for failing to provide financial support for the plan. Except at two prisons, *actual construction of clinical space has yet to begin*. R. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report) at 39-44.

20. Even if the Receiver were able to obtain immediate funding for his construction project, his target date for completion of the clinical upgrade program [7] is not until 2012, more than three years from now. It. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report, Exh. 1—Receiver's Turnaround Plan of Action) at 25-26.

A. Reception Center Clinical Areas Continue to be Inadequate for the High Volume of Medical Contacts.

21. In my initial report, I documented the significant space limitations at the Reception Center located at the California Institution for Men in Chino. The space limitations that I observed at the North Kern State Prison for reception center processing were as bad as the conditions I found at CIM. NKSP, a prison with a population of approximately 5,500 prisoners, including approximately 4,800 RC prisoners, receives approximately 500 new RC prisoners each week.

22. Under the *Plata* Inmate Medical Policies and Procedures, prisoners arriving at a Reception Center undergo a health screening on their day of arrival. Policies and Procedures, 4-2-1. "Licensed health care staff shall conduct interviews with inmate-patients in a manner that ensures the privacy of their health care information subject to the safety and security

concerns of the institution." *Id.* Reception Center prisoners must be provided a "complete history and physical examination performed by a Nurse Practitioner, Physician Assistant, or a Physician and Surgeon" within 14 days of arrival. P&P's, 4-2-2. The medical facilities that I observed at NKSP were inadequate for this purpose.

23. Arriving RC prisoners are delivered to the Receiving and Release area at NKSP. In this large open area, prisoners are interviewed, have their vital signs taken and receive a TB test, among other things, before proceeding to a housing unit. The initial health screening, which consists of an interview by an RN and administration of the TB test, takes place for most prisoners in a small [8] office just off the R&R area. Two nurses conduct interviews simultaneously, with prisoners sitting back to back, separated only by a shoulder-high divider. I was told that a third nurse sometimes conducts these medical interviews at a desk in the open receiving area, where prisoners and staff, circulate. Neither of these situations affords the necessary confidentiality for these critical initial health care encounters.

24. I questioned Dr. Emam, the facilities Chief Physician and Surgeon, about these conditions. He indicated that space is so limited, that there is no other space available in which these interviews may be performed. I believe that, given the lack of confidentiality for these encounters, prisoners are less likely to provide accurate information about sensitive medical and psychiatric conditions.

25. According to Dr. Emam, prisoners at NKSP are seen by a physician or mid-level provider for their medical history and physical examination within two to three days. I inspected the area where these

encounters take place. The area contains a series of very small rooms, each equipped with two chairs and a medical exam table. The exam table, however, functions as a desk for the medical provider, and the rooms are so small that it would be very difficult if not impossible to perform an actual physical examination in them. Dr. Emam acknowledged that the "exams" that take place are in fact simply medical interviews, primarily for the purpose of determining what type of housing is appropriate for the prisoner.

26. Adequate physical examinations are not performed on NKSP prisoners, despite the P&P requirements, which are based on the basic principle that incoming prisoners must undergo a comprehensive exam upon arrival so that [9] an adequate treatment plan may be developed and implemented. A physical exam, as opposed to a medical interview, is necessary because some conditions can be identified and confirmed only through physical examination of the patient.

27. Dr. Emam told me that the prison lacks the space to provide actual physical examinations for the high number of incoming Reception Center prisoners arriving daily at NKSP, and that, in any case, he lacks the physician staff to provide that service. The failure to provide a true physical examination creates the risk that certain medical conditions will not be timely identified and/or treated.

28. The Receiver has piloted a Reception Center screening process at San Quentin State Prison that, according to the Receiver, "provides integrated medical, dental, and mental health screening on the day of arrival as well as laboratory testing, medication review and administration, and referrals to providers based on national guidelines." Jt. Pls' Trial Ex. 67

(Receiver's Seventh Quarterly Report) at 7. The Receiver states that he intends to implement standardized reception center screening processes at the major reception center prisons by January 2009. *Id.* However, the Receiver frankly acknowledges that "[t]he most formidable challenge to progress at all the sites will be inadequacies in physical space and environment." *Id.*

29. Based on my review of the facilities available at NKSP, I do not believe that the Receiver's pilot Reception Center screening program can be implemented at that prison, without creating additional clinical examination facilities.

B. The Severe Shortage of Clinical and Office Space Described in My First Report Has Not Changed in the Last Six Months.

30. As noted above, the Receiver has concluded that the facilities [10] available for medical care delivery are "woefully inadequate." That is consistent with my findings during my November 2007 inspections, and is further supported by my observations during my most recent inspections.

1. NKSP's Clinical Space is Inadequate

31. At NKSP, the clinical spaces available for medical encounters following Reception Center processing and for the mainline prisoners are inadequate for the number of prisoners requiring medical attention.

32. NKSP is divided into five prison yards, denominated A-E. Yards B, C and D house only Reception Center prisoners awaiting transfer to a permanent institution. Yard A houses both general population prisoners (*i.e.*, prisoners who have been classified and endorsed to stay at NKSP) as well as Reception Center

prisoners, and Yard E, a minimum security facility, houses only mainline prisoners.

33. Each of the yards A-D has medical clinic space consisting of one exam room, a very small office in which the LVN prepares medications for distribution, a very small medical supply room, a dental clinic and a dentists' office.

34. Each yard is supposed to run at least two medical lines each day, one for the RN doing face-to-face triage, and one for the primary care provider (PCP) doing sick call. The yard medical clinics on A-D cannot accommodate simultaneous RN and PCP lines in the one available exam room. Accordingly, NKSP has created three exam spaces on B yard in an area that formerly housed custody offices, in which the RNs are now conducting face-to-face triage for yards B, C and D on Second and Third Watch (*i.e.*, 8 a.m. to 2 p.m., and approximately [11] 3 p.m. to 9 p.m.). The NKSP staff members refer to this area as the Reception Center Medical Clinic (RCMC).

35. While the clinical space allocated to the RNs in the RCMC is objectively adequate for performing screenings, data provided to me by the scheduler shows that prisoners are regularly not seen for their scheduled appointments. The fact that some prisoners going to the RCMC must be escorted from other yards for their appointments may contribute to this problem.

36. For example, I reviewed the nurse triage tracking data for the week of August 18, 2008 for prisoners from D-yard. *Plata* Pls' Trial Ex. 36. During that week, of the 119 appointments schedule, more Chant 50% (61) did not take place. While the tracking form states that five prisoners were not seen because of a

yard change, one paroled and one was at a different medical appointment, the primary reason stated for the missed appointment was "lockdown," "out of time," or "short nurses." I strongly suspect that the location of the clinic on a different yard means that the triage line runs slower, resulting in fewer patients being seen timely.

37. I was told that patients who are not seen for their appointment are given an appointment on the next available triage line, usually two days later. However, I reviewed D-yard's August 18-22 nursing tracking data, and found that of the 14 patients who were scheduled but not seen on August 18, just three patients were rescheduled and seen that week, while ten were either rescheduled but not seen, or not rescheduled within the week. *Id.* (One prisoner transferred or paroled.)

38. The A-yard prisoners do not go to the RCMC for nurse triage. [12] Because the PCP runs a sick call line in the only medical exam room, the RN does face-to-face triage in the hallway, with the prisoner sitting in a chair, within several feet of the prisoners awaiting their appointments. The RN states that, if she decides she needs an exam table for these encounters, she must wait until the PCP is between patients, and then use that office. The triage encounters cannot be maintained confidential under these circumstances; thus, the RN's ability to obtain reliable information from their patients is critically impaired.

39. Prisoners who are housed in the Administrative Segregation Units on A-yard and D-yard are seen for RN triage and for sick call encounters in a meeting room in the housing unit. It is not set up with any medical equipment. Without necessary medical

equipment, including an exam table, the medical staff cannot provide adequate medical care.

2. SATF's Clinical Space is Inadequate

40. The Substance Abuse and Treatment Facility at Corcoran is one of the largest prisons in the system, with approximately 7,000 prisoners housed on seven yards, A-G. Each of the prison yards has its own clinic, with an exam room for the RN performing triage, and a second room for the PCP seeing patients for sick call.

41. At SATF, the medical staff reported that there were 1,200 overdue primary care appointments. I was told that, in an effort to address the backlog, SATF had on the day of my visit three CDCR physicians from the Central Office, whose mission was to visit, at their cell front, prisoners who had submitted sick call slips to determine what medical care they required, if any. I was told that primary care providers will be performing cell front triages two days a week, [13] every two weeks, for the foreseeable future.

42. The SATF staff said that the physicians were seeing patients in the housing units at their cell fronts because SATF lacked exam space for them to use for these medical encounters. Such encounters, which take place with custody officers and fellow prisoners within earshot, are not an adequate substitute for clinical encounters in a private, medically equipped setting.

3. PVSP's Clinical Space is Inadequate

43. Dr. Igbinosa, the Chief Medical Officer at PVSP, reported that he is currently authorized to hire 14 primary care providers to care for the 5,200 prisoners at PVSP. If he were able to fill all primary care

positions, he advised me that he would not have the space for them.

44. Dr. Igbinosa further related that he would like to have more specialty providers from the outside community provide care to prisoners on-site at the prison. Although some specialists do currently see patients at the prison periodically, Dr. Igbinosa said that he cannot expand this program because he lacks the necessary clinical space to accommodate the providers.

4. CSP-Solano's Clinical Space is Inadequate

45. At SOL, the Annex Clinic, which serves the needs of the approximately 1,750 prisoners housed at the prison's Facility 4, is located in what had been an area used for education programs, and the space is still used for education programs as well as prison classification committee activities. The main patient encounter area is a small room in which patients are seen by one of three primary care providers who work in the room. The room is divided into three [14] medical encounter areas by five foot tall wood and cloth partitions or screens. The three patient encounter areas are immediately adjacent to one another, such that a conversation in one can be heard in the others. This space does not provide for adequate patient confidentiality. A PCP also sees patients in the Annex Clinic's main work room. There, a thin hospital bed style curtain separates the patient and PCP from the clinic's other business.

46. All available space in SQL's medical clinics was being used. SOL does not have adequate space for its current complement of PCPs to work in, let alone additional PCPs should the prison hire such additional staff.

5. Receiver's Assessment of Other Prisons' Medical Space

47. I reviewed operational assessments prepared for the Receiver regarding several of the CDCR prison facilities.

a. California Rehabilitation Center (CRC)

48. The January 2008 operational assessment regarding the CRC conducted by the Receiver's office concluded that all medical spaces are in urgent need of repair, and that, "[for the most part, none of the existing areas occupied by health care clinicians are clinically appropriate." Jt. Pls' Trial Ex. 100. (California Prisoner Health Care Receivership Corporation, Operational Assessment for Access to Care at the California Rehabilitation Center) at 15.

b. California Training Facility—Soledad (CTF)

49. A review of CTF conducted by CDCR and Receiver staff in March 2007 determined that the prison's Central Facility clinic is so crowded and has such limited space that "[i]nmates that are ducatted for health care usually wait for hours to see the provider," the North Facility clinic is "very small based on the [15] number of inmate-patients being served," and that the South Facility clinic area, although the newest physical plant of the three facility clinics at the prison, was "built to support an inmate population of 510 inmates and not the current housing of more than 1000 inmates." Jt. Pls' Trial Exh. 99 (Operational Assessment, review conducted in March 2007) at 2-3.

c. Mule Creek State Prison (MCSP)

50. The December 2007 operational assessment report regarding MCSP conducted by the Receiver's

office concluded, "[a]ll of the Facility Clinics are undersized for the quantity of inmate/patients seen on a daily basis and lack[] appropriate holding/waiting space for inmate/patients ducated to be seen by health care providers." Jt. Pls' Trial Ex. 101 (Operational Assessment for Access to Care at Mule Creek State Prison) at 7. The assessment also pointed out that although Mule Creek's "size and overall design . . . is likely one of the most manageable . . . anywhere within the State . . . ", it is "no exception" to the "system wide barrier" of "serious space deficiencies for clinical staff," which have existed at 14ll of the CDCR facilities the Review Team has visited . . ." *Id.* at 28.

51. The Receiver plans to address medical facility deficiencies at existing prisons by assessing those prisons' needs, developing plans and then upgrading or constructing necessary facilities. The Receiver's Plan provides that assessments, plans and will be done on a phased and serial basis. The assessments are scheduled to be completed by January 2010. The target date for completing all upgrades and construction is January 2012. Jt. Pis' Trial Ex. 56 (Receiver's Eighth Quarterly Report, Exh. 1—Receiver's Turnaround Plan of Action) at 25-26.

[16] 52. As of June 2008, Avenal and San Quentin were the only two existing prisons at which medical facility construction upgrades had begun. Jt. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report) at 39-44. Avenal was scheduled to have construction completed in July 2009. *Id.* at 40. San Quentin had some projects completed; most projects there were scheduled to be completed in February 2009 with the final project (the central health services building) scheduled to be done in April 2010. *Id.* at 42-44.

53. NKSP, SATF and SOL, where, as discussed above, clinic space is inadequate, are in the final group of 13 prisons scheduled to be assessed and to have upgrades completed (by 2012) . Jt. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report, Exh. 1—Receiver's Turnaround Plan of Action) at 26. Thus, in the best case—if the Receiver's timetable has no slippage at all—tens of thousands of prisoners will continue to be incarcerated in prisons with inadequate medical facilities for the next three plus years.

V. THE NUMBER OF CLINICIANS CONTINUES TO BE INSUFFICIENT FOR THE NUMBER OF PRISONERS WHO REQUIRE MEDICAL CARE.

54. In my previous report, I stated that overcrowding creates pressures on the system that make hiring and retaining sufficient numbers of clinicians and other medical workers exceedingly difficult, and that California's overcrowding crisis has created a situation where the prisons, and particularly the more remote prisons, are unable to hire and retain enough health care staff to address the medical needs of the prisoner-patient population. Based on my most recent inspections and my review of the vacancy data from May 2008, my opinion remains unchanged.

[17] A. CDCR Still Cannot Fill Some Vacancies

55. Even after the Receiver substantially raised salaries for medical staff, the vacancy rates at some prisons remain high. The May 2008 vacancy and registry report provided by the *Plata* health care support division shows on-going serious problems in hiring primary care providers (PCPs), and even with having adequate numbers of such providers on site. *Plata* Pls' Trial Ex. 35 (*Plata* Vacancy/Registry Report, May 2008) at 1. The report shows that statewide there

was a 25 percent vacancy rate in primary care provider positions; the vacancy rate adjusted to account for PCP employees on leave in May was 35 percent. *Id.* Further, the report shows that in May the prisons statewide had a shortfall of 56 PCPs even after temporary, overtime, and contract/registry PCPs used to reduce vacancies were taken into account. *Id.* Consistent with this statewide vacancy report, four of the five prisons I inspected in August have had critical, ongoing problems filling their primary care positions with state employees.[1]

1. NKSP

56. According to the *Plata* Vacancy/Registry Report for May 2008, NKSP had a total of 16 primary care provider positions, of which 6.6 were unfilled, for a vacancy rate of 41%. *Id.* at 12.

57. Dr. Emam, the acting Chief Physician and Surgeon at NKSP advised me that the prison had very recently succeeded in hiring some primary care providers, but that it has been extremely difficult to fill the vacant positions. He [18] reported that the prison continued to have two line physician vacancies and that that they had also been unable to fill the Chief Physician and Surgeon position that he has been filling on a temporary basis.

2. SATF

58. The May 2008 Vacancy Report shows that SATF had 13 primary care positions allocated, of

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[1] CSP-SOL, the fifth prison .I visited, did not have an adequate allocation of PCP positions. See Part V.B, below. Further, as discussed above (see Part IV.B), the prisons, including CSP-SOL, do not have adequate clinic space for PCPs to see prisoner-patients.

which one was filled with a state physician, but that person was on leave. *Id.* at 15.

59. The Report shows that SATF hired 7.7 registry providers at that time to deliver primary care. *Id.*

60. When I inspected the prison, Dr. Enenmoh, the acting Chief Medical Officer, advised me the prison still had just one state employee physician, and that recruiting for the physician positions, and for the unfilled Chief Physician and Surgeon position, had been very difficult. He had eight contract physicians and two contract mid-level providers.

3. PVSP

61. The May 2008 Vacancy Report shows that PVSP had 14.8 allocated primary care positions. At that time, PVSP had just one state employee primary care provider. The prison contracted with 5.1 registry primary care providers. *Id.* at 13.

62. According to Dr. Igbinosa, as of the date of my inspection, the prison had the equivalent of eight full-time primary care practitioners. He explained that it is extremely difficult to recruit medical professionals to work at the prison because it is so remote. Most contract providers currently providing care at the prison live in Los Angeles or San Francisco and commute to the prison [19] on an intermittent basis. One physician commutes from Chicago twice a month, for a week each time. Dr. Igbinosa said that none are willing to relocate to the Central. Valley. He noted that, even when candidates at hiring fairs express interest in working at PVSP, they often retract their application when they realize that they can earn the same CDCR salary and live in or near an urban environment. As a consequence, PVSP has

too few primary care providers to care for the number of patients at the prison.

4. HDSP

63. The May 2008 Vacancy Report shows that HDSP had 8.0 allocated primary care positions, and that two were vacant in May. *Id.* at 10. However, on the date that I inspected High Desert in August 2008, Chief Medical Officer Dr. Swingle advised me that, although HDSP appeared to have four state physicians, all four were either on leave or stripped of their clinical privileges.

B. Some Prisons Are Still Allocated Too Few Providers

64. At SOL, the prison is authorized 9.0 staff primary care provider (PCP) positions. The health care manager stated that the prison was making a request to add two more staff PCP positions, so that there would be a total of eleven. The chief medical officer, however, said that the prison needs a total of 13 PCP staff positions, given the number of medical encounters.

C. Use of Registry Still Cannot Resolve Staffing Shortfalls

65. The heavy use of registry providers is, as I explained in my initial report, a stop-gap measure that mitigates harm to individual patients in the short-term, but is not an adequate long-term solution. Solano's Chief Medical Officer, Dr. Traquina, indicated that there is a rapid turnover in registry personnel, and it is [20] difficult to build a medical care delivery program with staff who do not intend to make a substantial time investment at the prison.

66. Because registry physicians tend to turn over quickly, the prisons end up spending time doing extensive on-the-job training repeatedly, which is time-consuming and detracts from patient care delivery.

D. Clinical Staff Shortages Continue to Result in Delayed and Inadequate Care

67. At each prison I inspected in August, there were delays in triaging patients' sick call slips, and in primary care visits, because the clinicians were unable to keep up with the heavy demand for medical care.

68. At most of the prisons I inspected, the staff reported that, although there are backlogs of patients waiting to see their primary care providers, the staff does triage to ensure that the sicker patients are seen first on the primary care provider lines. The defendants have not, however, demonstrated a method for this triage or that they evaluate or track whether this triage is effective.

1. NKSP

69. At NKSP, I reviewed the tracking data for the D-yard primary care provider sick call line for the week before my inspection, August 18-22. *Plata* Pls' Trial Ex. 37. I found that the clinic had scheduled 94 appointments, but that the primary care provider had not seen 27 (29%) of those patients. The most common reasons cited on the tracking instrument were that the clinician ran out of time, or did not have the patient's Unit Health Record.

2. SATF

70. At SATF, the prison's Health Care Manager, Gayle Martinez, reported that SATF had a backlog of 1,200 overdue primary care appointments. [21] The

prison has a far greater demand for services than the staff at SAIF can deliver.

71. I interviewed the Office Technicians and reviewed sick call slips on four of the seven prison yards (A, C, E and G). I found that, on each of the yards, it usually takes two to six days for prisoners to see a nurse for a triage appointment. (These appointments are supposed to occur within one business day of receipt of the patient's sick call slip.) For example, on E-yard, I reviewed the stack of sick call slips for the patients scheduled to see the RN on August 27. The sick call slips were marked received on August 21-25.

72. On each of the four prison yards I inspected, the Office Technicians reported, and the sick call slips demonstrated, that it takes roughly four weeks for primary care appointments, once the patient has been referred to the primary care line on a routine basis.

3. PVSP

73. I was told by PVSP staff that the wait for routine primary care provider appointments is two to four weeks.

4. Solano

74. At SOL, there are major delays for routine appointments with a primary care provider at each of the prison's three clinics (Primary, Sattelite, and Annex). In the Primary clinic, it takes 16 weeks for such an appointment. In the Satellite clinic, it takes six to eight weeks. In the Annex clinic, the backlog is eight to ten weeks, even with primary care provider appointments taking place on Saturdays. The Primary clinic also has a backlog of face-to-face appoint-

ments with registered nurses; such appointments take about ten days to occur, even [22] though the clinic had run triple lines of such appointments on weekends.

5. HDSP

75. At each of the four main medical clinics at HDSP there are significant delays for routine appointments with a primary care provider (PCP). In "A" facility clinic, routine appointments are scheduled six weeks after a nurse determined that patient should be seen by such a provider. In "B" facility clinic, such appointments are scheduled approximately 16 weeks after such determinations. In "C" facility clinic, such appointments are scheduled approximately eight weeks after such determinations. In "D" facility clinic, such appointments are scheduled approximately 4 weeks after such determinations.

76. The "C" and "D" facility clinics also had backlogs for routine registered nurse face-to-face triage appointments; those appointments are scheduled two and four to five days, respectively, after the prisoner's written request for medical attention was received.

77. The HDSP CMO was not surprised, during the file reviews, to find that documents are placed in UHRs without having the practitioners review them, and the follow-up with PCPs are not timely scheduled. These documents include CT scan, ultrasound, and consultation reports. She was also not surprised that the files demonstrated substantial treatment delays. She advised me that HDSP lacked the staff and resources to treat the number of prisoners at the facility.

E. Inspected Prisons Still too Shortstaffed to Implement Required Programs.

78. Because there are too few clinical staff members to provide adequate treatment to the number of prisoners incarcerated, some prisons have failed to fully implement certain essential medical programs.

[23] 1. NKSP

79. For example, as explained above, NKSP has a large reception center, and thus is tasked with processing arriving prisoners and classifying them for transfer to permanent prisons. Given the acute staffing shortage, coupled with the lack of clinical exam space, NKSP has been unable to provide incoming prisoners with the required comprehensive physical examination. Instead, these prisoners are simply undergoing a second medical interview, several days after their initial interview with an RN.

80. Additionally, based on my review of a sample of unit health records (UHR), I believe required follow-up appointments with primary care providers are not being done for a substantial number of patients. I reviewed 13 UHRs for prisoners sent offsite approximately one month before my inspection (either for scheduled or unscheduled appointments) for whom documentation of the offsite visit and follow-up with the PCP should have been in the file for minimally adequate care. I found that nine of the 13 UHRs lacked documentation of a timely follow-up with a physician, and eight lacked required documentation of the service or hospital visit.

2. SATF

81. At SATF, I visited four prison yard clinics. In none of these clinics was the staff maintaining an

"Urgent/Emergent Log Book." Each yard is supposed to have an Urgent/Emergent Log book, in which the staff records each encounter in which a prisoner reports an urgent or emergent condition. P&P, 4-12-1. These logs play an important role in continuity of care, because the primary [24] care provider assigned to each yard clinic is required to review the log each work day to determine whether any patients require further follow-up. P&P 4-12-3. Without this link, I believe some patients who do require urgent follow-up attention will fail to receive it.

82. I reviewed 11 UHRs for prisoners who had transferred to SATF two weeks earlier and had significant medical conditions. Based on these records and the available documentation, I concluded that for ten of the eleven patients, medically necessary follow-up had not occurred. The problems I identified included missed medications and lapsed chronic care follow-up visits with a primary care provider.

83. Additionally, the UHRs lacked documentation of required primary care follow-up appointments. I reviewed nine UHRs for prisoners sent offsite approximately one month before my inspection (either for scheduled or unscheduled appointments) for whom documentation of the offsite visit and follow-up with the PCP should have been in the file for minimally adequate care. I was unable to find documentation of a PCP follow-up in four records. For three of those four medical records, there was also no documentation from either the hospital or specialist regarding the encounter. Some patients who receive medical attention off-site but are not adequately followed up by their primary care providers upon return to prison will be at serious risk of harm because necessary treatment will either lapse, or not be ordered.

84. The SATF medical staff advised me that they are unable to schedule timely follow-ups in many cases because they have too few medical providers for the number of prisoners requiring treatment.

[25] 3. PVSP

85. I reviewed the UHRs for 23 prisoners sent offsite approximately one month before my inspection (either for scheduled or unscheduled appointments) for whom documentation of the offsite visit and follow-up with the PCP should have been in the file for minimally adequate care. According to the UHRs, 12 of 23 prisoners did not receive timely follow-up appointments. Eleven of the 23 UHRs were missing required documentation, including ER reports, consult reports, etc.

4. SOL

86. At Solano, I reviewed 14 records of patients sent offsite approximately one month before my inspection (either for scheduled or unscheduled appointments) for whom documentation of the offsite visit and follow-up with the PCP should be in the file for minimally adequate care. I found that just seven of the files contained documentation of timely follow-up, and in four UHRs, required documentation of the offsite medical encounter was missing.

5. HDSP

87. At HDSP, I reviewed 15 records of patients sent offsite approximately one month before my inspection (either for scheduled or unscheduled appointments) for whom documentation of the offsite visit and follow-up with the PCP should have been in the file for minimally adequate care. In eleven cases, there was no documentation of a timely PCP follow-up visit, and in nine cases, there was missing documentation.

My review uncovered other serious problems. For example, one patient was ordered an urgent MRI of the [26] brain on July 8, 2008. There was no documentation that the MRI had occurred as of August 29, 2008.

VI. PLAINTIFFS ARE STILL NOT RECEIVING TIMELY SPECIALTY CARE

88. Although defendants have added contract specialty providers, the prisons I inspected still cannot schedule timely "high priority" visits in a large number of cases. PCPs request offsite specialty appointments on a "high priority" basis when the patient has an urgent medical need, and these appointments are supposed to be scheduled within 14 days of the request for services. P&P 4-8-1. The demand for care, particularly for the high priority cases, continues to overwhelm the resources available to the defendants. Additionally, some facilities have proven unable to obtain timely reports from the specialty providers, resulting in unnecessary treatment delays. (See paras. 80, 83, 85-87 above.)

A. PVSP

89. At PVSP, the offsite aging specialty report included 55 high priority referrals as of August 27, 2008. *Plata* Pls' Trial Ex. 38. Of those, 11 had been pending for over 14 days, yet had no appointment scheduled, and of those scheduled, 19 were scheduled to take place more than 14 days after the referral. Thus, well over half of the PVSP patients are unable to receive timely high priority appointments.

B. SOL

90. The situation at SOL was worse. There, 63 high priority off-site specialty appointments were listed on

the aging report for such appointments. *Plata* Pls' Trial Ex. 39. None were scheduled for a date within 14 days of the primary care provider request. Most of these urgent referrals—approximately 40—[27] did not yet even have an appointment date; four of these cases had been already pending at least 20 weeks, four others at least 15 weeks, three others at least 10 weeks, and another approximately one dozen between four and eight weeks. Of the approximately two dozen high priority off-site specialty referrals that had appointment dates scheduled, about 12 were scheduled to take place more than approximately five weeks after approval, with a few of these being scheduled four to five months (or longer) after approval. Another approximately one dozen were scheduled to take place three or four weeks after the approval date.

C. HDSP

91. At HDSP, 48 high priority off-site specialty referrals were listed on the aging report. *Plata* Pls' Trial Ex. 40. Only one was scheduled for a date within 14 days of the primary care provider request, as required for these urgent referrals by the court-approved policies. Three other referrals were scheduled to take place between 14 and 21 days after the approval date. Seven other high priority referrals had appointments scheduled, with dates ranging from four to eight weeks after the approval date. The vast majority of the urgent off-site specialty referrals—37 of the cases—did not yet even have an appointment date with the requested specialty provider. Approximately 20 cases without an appointment date scheduled had been pending for at least six weeks; half of these had been pending for more than two months.

D. NKSP

92. At NKSP, of the 70 listed high priority offsite specialty referrals, 22 (31%) had been pending for more than 14 days and had no appointment scheduled. *Plata* Pls' Trial Ex. 41. Twelve more were scheduled, but more than 14 days had [28] elapsed between the referral and the appointment. Nearly half the appointments currently listed as "high priority" NKSP will not take place within the required timeframe.

93. When specialists see CDCR prisoners or when prisoners are seen for certain procedures, the service provider must provide the sending prison with a report of the encounter. The CDCR primary care provider then uses that report to determine the prisoner's treatment plan.

94. Based on my reviews of unit health records at NKSP and PVSP. I concluded both prisons have a serious problem obtaining these records.

VII. MEDICATION MANAGEMENT PROBLEMS

95. In my initial report, I found that defendants' medication delivery systems were inadequate for the size of the population they serve, and were plagued by short-staffing at a number of prisons. Based on my most recent inspections and my review of the report by Pablo Stewart, M.D., it is still my opinion that the defendants' medication delivery system is inadequate for the population it serves. Because there are too many prisoners, coupled with too few staff and insufficient resources, the system suffers from medication delays and inadequate treatment documentation. Some prisoners continue to receive their medication late, or not at all, and suffer as a result.

96. The Receiver is rolling out a new medication delivery system under the auspices of Maxor. At SAIF, the Maxor system was initiated in April 2008. The staff reported that they continued to find "bugs" in the system, and that the biggest issue was that refills were not being provided timely. The staff also reported that the system was considerably more labor-intensive than the previous [29] system, requiring additional clerical work, and yet the prisons were not provided additional clerical support positions.

97. In its annual report to the Receiver for 2007, Maxor recognizes that overcrowding significantly impacts its ability to deliver medications:

> Overcrowding: The impact of overcrowding on the system's abilities to provide timely and effective delivery of necessary medications is significant. A clear example of this impact was noted at San Quentin. San Quentin receives 75-80 new prisoners each day and presumably transfers out or releases about the same number. Overcrowding however, forces a series of "compaction" moves resulting in as many as 300-400 separate prisoner moves each day in order to free up appropriate housing for the offenders. This constant "churn" of prisoners within the institution keeps the healthcare staff chasing prisoner movement to ensure medications can be delivered in a timely fashion. . . . This takes time, and in some cases, the medications are simply returned to the medical area to try to determine where the prisoner is housed. During this time, the prisoner patient is not getting his medications and may complain to staff who in turn—reorders the medications, resulting in duplicate work.

Jt. Pls' Trial Ex. 67 (Receiver's Seventh Quarterly Report, Exh. 6) at 29.

VIII. OVERCROWDING FUELS DYSFUNCTION IN MEDICAL RECORDS

98. As I explained in my first report, health care records are a critical component of any adequate medical delivery system. Unless medical records and scheduling information are managed, organized, and maintained effectively, appropriate health care services cannot be provided. Overcrowding continues to make it impossible for CDCR to perform these essential functions.

A. Quality of Medical Records Continues to be Poor at Inspected Prisons.

99. Although the Receiver has long-term plans to develop an electronic medical record, those plans are unlikely to come to fruition for years. In the meantime, California relies on paper medical records (except at Pelican Bay State Prison). At each of the prisons I inspected, I found that the medical records were [30] unwieldy, rarely organized chronologically and, in general, poorly maintained. Retrieving useful information from the files invariably requires considerable time sifting through extraneous reports, misfiled documents and outdated materials. At the same time, certain documents that would be extremely useful, such as an updated "Problem List" for each file, which is required by the court-ordered *Plata* Policies and Procedures, are typically missing.

100. There are dangerous widespread delays in filing medical documents at HDSP. After I had provided HDSP medical staff with a list of the names and CDCR numbers of the prisoners whose unit health records (UHRs) I wanted to review, someone

from the prison went through medical records' loose filing (documentation not yet placed in individual patient UHRs) to find any documents for the patients whose charts I was going to review. These documents were then brought to the room where I reviewed the UHRs. The documentation retrieved from loose filing included documents more than a month old, including, for example, the result of a CT Scan received by the prison in July. More alarming, most of the documents in loose filing, some of which had been received a month before my site visit, had not yet been initialed as reviewed by a primary care provider.

101. In addition, Dr. Swingle, the HDSP Chief Medical Officer, reported that the transcribing of dictated primary care provider notes was "several months" behind at the prison. This means that documentation of a PCP-patient encounter is missing in the UHR. This, combined with the backlog in loose filing described above, creates dangerous risks because medical staff members who provide care to the patient have no idea what assessments were made previously or, in some cases, [31] what diagnostic test results were obtained.

B. CDCR Continues to Rely on Inadequate Tracking Systems

102. CDCR's tracking and information systems cannot keep up with the overwhelming data requirements in the system's overcrowded prisons. In support of his Seventh Quarterly Report, the Receiver submitted a February 6, 2008 report entitled "Patient Identification Assessment." Jt. Pls' Trial Ex. 67 (Receiver's Seventh Quarterly Report, Exh, 11 There, the consultant concluded that "the information technology environment within the medical care side of the CDCR is not a 'system' . . . it is an act of

desperation." *Id.* at 5, emphasis in the original. The report further explains that, because the defendants cannot identify and link previous diagnostic and treatment information across prison sites, they face risks including "the possibility of significant errors during patient treatment . . . [and the] inability to identify individuals with chronic and/or communicable conditions upon reincarceration . . . ." *Id.*

103. The Report explains that these problems are magnified in the CDCR due to several factors, including "overcrowding in the prisons (increasing the risk of communicable disease transmission) . . ." *Id.* "Due to debilitating technology and record management practices, pulling together a cohesive picture of the inmate's health status is a significant challenge, and currently is near impossible. This puts continuity of care at risk." *Id.* at 6.

104. I agree with this report that the information systems currently in place in the CDCR are inadequate, and place prisoners at risk of harm.

IX. THERE ARE STILL NOT ENOUGH CUSTODY OFFICERS TO ENSURE ADEQUATE ACCESS TO MEDICAL APPOINTMENTS AND CLINICAL CONTACTS AT SOME PRISONS.

[32] 105. As the Receiver explained in his Turnaround Plan in June 2008,

> Health care services are meaningful only if patient-inmates have timely access to those services. In a correctional setting, issues of access are inextricably intertwined with control and supervision of inmate movement by custody staff. System-wide, CDCR lacks the custody staff and organizational structure and processes to ensure that patient-inmates are reliably escorted and/or

> transported to medical appointments. As a result, patient-inmates are often denied timely access to health care services, substantially increasing the risk that patient-inmates' health will further deteriorate and increasing the overall costs of providing health care services.

Jt. Pls' Trial Ex. 56, (Receiver's Eighth Quarterly Report, Exh. 1—Turnaround Plan of Action) at 5.

106. The Receiver has added additional custody teams to facilitate timely medical appointments, but his overall plan does not call for the full implementation of these additional custody allocations until July 2011, "contingent upon recruiting and training sufficient numbers of correctional officers to fill the new health care access posts." *Id.* at 6.

107. At some of the prisons I inspected, prisoners are unable to access medical care appointments based on custody shortages. When a prison yard is placed on "modified program" status, *i.e.,* either all prisoners or some racial subgroups must be escorted to the clinics, often in shackles, there are often significant delays in treatment. These delays arise because there are not enough custody officers to move the prisoners in and out of the clinics on a timely basis, so far fewer prisoners are seen in the clinics.

A. PVSP

108. I was told by custody staff that the B-yard at PVSP has been locked down during the last two months. The appointment tracking data for PVSP for the [33] month of August (through August 14) shows the dramatic drop off in completed patient appointments on B-yard. *Plata* Pls' Trial Ex. 42 (PVSP Physician Appointment Statistics, August 2008). During the first two weeks of August, primary care providers

on yards A, C and D saw 258, 193 and 215 prisoners, respectively. On B-yard, the primary providers saw 118 prisoners during the same period. Indeed, on August 7, two providers were scheduled to see 42 patients, but just ten patients were seen. *Id.* The reasons stated on the tracking list were "alarms, LD [presumably lockdown]; no escorts." *Id.*

109. The tracking statistics for the RN triage appointments likewise reflect a drop for completed patient triage appointments for B-yard patients. *Plata* Pls" Trial Ex. 43 (PVSP RN Appointment Statistics, August 2008). While A, C and D completed 215, 121 and 129 triage appointments, B-yard nurses completed just 98, or fewer than ten appointments per clinic day. *Id.* The reasons provided for the cancelled appointments included, "lockdown," "no escorts," and "alarms." *Id.*

110. Additionally, on B-yard, the staff advised me that it took one business day from the date of collection of sick call slips to the date of the face-to-face triage appointment. However, when I questioned the office technician further about the scheduling, he stated that because the yard was on lockdown, he had to schedule prisoners for their triage appointments by race/gang affiliation, with each subgroup having one day a week for appointments. Thus, he was able to schedule timely RN triage appointments in only a handful of cases.

B. HDSP

111. At HDSP, the prison routinely has what the Warden describes as [34] rolling lockdowns, in which half of the prison's four main housing facilities are locked down at any one time because the prison does not have enough correctional officers to operate all

facilities without using overtime. When there is such a lockdown on the two HDSP facilities used to house maximum custody prisoners, access to medical care is affected because such prisoners must be escorted to the medical clinics. When there is a lockdown in "D" facility, the primary care provider will be able to see between 12 and 20 patients a day, instead of the 20 that can be seen if there is no lockdown.

X. THERE ARE MORE PRISONERS REQUIRING SPECIALIZED PLACEMENT FOR MEDICAL REASONS THAN CDCR CAN ACCOMMODATE

112. In my first report, I agreed with the Receiver's opinion that the CDCR is currently unable to accommodate the housing needs of medical patients requiring specialized placement. My opinion has not changed.

113. In his Turnaround Plan of Action, the Receiver discusses his plan to expand facilities to accommodate the 10,000 state prisoners "whose medical and/or mental condition requires separate housing to facilitate appropriate, cost-effective access to necessary health care services." Jt. Pls' Trial Ex. 56 (Receiver's Eighth Quarterly Report, Ex—Turnaround Plan of Action) at 27. The Receiver explains these facilities must be built because "CDCR does not have adequate clinical, administrative and housing facilities to support constitutionally adequate health care." *Id.*

114. As the Receiver explained in his Eighth Quarterly report, the current lack of medically appropriate housing for medically fragile prisoners can have dire consequences. "Simply stated, before constitutionally adequate health care can be [35] delivered in California's prisons, there needs to be *constitutionally*

adequate treatment facilities to provide such care. Unless and until these facilities are constructed, the major health care class action cases will continue indefinitely. Likewise, prisoners will continue to die unnecessarily." Jt. Pls' Exh. 56 at 46. (Emphasis in the original.)

115. I understand that defendants have failed to provide the Receiver with the necessary funding for the construction, and the Receiver recently moved for contempt against the Governor and the State Controller for their failure to provide the funding. To my knowledge, no construction has yet begun on this essential project.

XI. IT WILL TAKE YEARS FOR THE RECEIVER'S TURNAROUND PLAN TO REMEDY THE UNCONSTITUTIONAL MEDICAL CONDITIONS

116. On June 6, 2008, the Receiver submitted to the Court a "Turnaround Plan of Action" designed to correct constitutional deficiencies in the California prison health care system. I have reviewed the Receiver's Turnaround Plan.

117. In his August 5, 2008 newsletter, the Receiver wrote that the Turnaround Plan "consists of over two dozen complex projects, initiatives and programs. Any one of these major projects would be enough to challenge an ordinary department." Jt. Pls' Trial Ex. 102 (August 5, 2008 Newsletter from the Receiver.) I agree that the plan is enormously complex, and I believe that it will take years to remedy the current unconstitutional conditions. The timeframe to reach a constitutionally adequate medical delivery system will be delayed if crowding is not reduced.

XII. OVERCROWDING INCREASES THE RATE AND SERIOUSNESS OF INFECTIOUS DISEASE TRANSMISSION

[36] [missing text] the converted gyms, create potential breeding grounds for disease.

XIII. CONCLUSIONS

119. Based on all that I have set forth above and in my previous reports, I continue to believe that overcrowding is the primary cause of the current stale of medical crisis in the CDCR. I do not believe the Receiver and. he CDCR will be able to address and resolve the critical medical care deficiencies until the need for services within the system is significantly, reduced, and I still believe that some of the hiring gains for clinicians will be lost if these systemic issues are not addressed, because many newly-hired clinicians will be unwilling to risk their professional credentials and reputations by practicing in an environment where their patients are at risk of harm because, among other things, adequate clinical space is scarce, appointments are not scheduled, complete medical records are unavailable, and medications are not timely delivered.

Dated: 9-9-08

/s/ Ronald Shansky
Ronald Shansky M.D.

SUPPLEMENTAL REPORT OF JEANNE WOODFORD

Coleman v. Schwarzenegger et al.,

No. Civ. S-90-0520 LKK

Plata v. Schwarzenegger et al.,

No. C01-1351 T.E.H.

AUGUST 2008

[1] SUPPLEMENTAL REPORT OF JEANNE WOODFORD

A. Introduction

1. On November 9, 2007, I submitted a report on the effects of overcrowding in California's prisons. At that time I concluded that overcrowding is the primary cause of the constitutional violations in these two cases, that a prison construction program will not alleviate the unconstitutional conditions and that the prison population must be substantially reduced for there to be any realistic hope that the unconstitutional conditions will be eliminated.

2. Since that time the population of the prison system has remained essentially unchanged, with the exception of a few thousand prisoners that have been transferred to private out-of-state prisons. In November 2007, there were 163,834 prisoners in institutions and camps, which is 199% of design capacity. As of July 30, 2008, there were 159,326 offenders in institutions and camps which is 191% of design capacity. Compare Weekly Reports of Population for July 30, 2008 and November 7, 2007, Data Analysis Unit, California Department of Corrections and Rehabilitation. Almost the entire difference is attributable to the 4,606 prisoners in out-of-state facilities.

3. After considering this information and inspecting three California prisons in the last month, it is still my opinion that the CDCR remains severely overcrowded, that this overcrowding is the primary cause of the constitutional violations and that the prison population must be substantially reduced to alleviate the unconstitutional conditions. In my opinion, the state can and should safely [2] reduce the prison population to an appropriate level that allows prisoners to receive, and staff to provide, the health care to which they are entitled and the programming that will keep all of us safe. I have read that the strike team appointed by the Governor to implement AB 900 has concluded that CDCR should not exceed 130% of design bed capacity in the long term, and should establish measures to ensure that this crowding level is not exceeded in the future. Joint Pls Trial Ex. 74 at 6 (Validation of In-Fill Bed Plan, AB 900 Strike Team Issue Memo No. 1, August 13, 2007). I agree with this position, with the caveat that different (and particularly older) facilities might require slightly lower population limitations, based on the quality of infrastructure and availability of treatment space, for example.

4. I inspected the Correctional Training Facility at Soledad (CM on July 23, 2008, the California State Prison at Corcoran (Corcoran) on July 24, 2008, and the California State Prison—Los Angeles at Lancaster (Lancaster) on August 7, 2008. I was accompanied on the tour by prison officials, a representative of the Receiver's office and a Deputy Attorney General. I was provided with access to all areas of the prison and any documents or prisoner files that I requested. Both custody and health care staff answered all of my questions.

5. All three of the prisons that I inspected are severely overcrowded by any measure. CTF was 197% overcrowded on July 23, 2008, housing 6,500 prisoners in a facility designed for 3,312. Weekly Report of Population for July 23, 2008; Data Analysis Unit, California Department of Corrections and Rehabilitation. [3] Corcoran was designed for 3,116 prisoners; but was housing 5734 on July 23, 2008, 184% of design capacity. *Id.* Lancaster housed nearly 5,000 prisoners on July 23, 2008, in a prison designed for 2,300, an overcrowding rate of an astounding 216%. The three prisons I visited confirmed my opinion that overcrowding negatively affects the entire operation of a prison. Although this is manifested in different ways, it is obvious that the overcrowding itself is very dangerous and is preventing the state from providing the necessary services to prisoners.

6. Even the remedies the state uses to alleviate crowding cause problems for an already overburdened staff For example, at CTF the medical department was swamped with work because they had been ordered to review 1,500 medical files to determine which prisoners were eligible for transfer to out-of-state prisons.

B. Housing Units

7. All three prisons were housing prisoners in areas not designed for that purpose. At Lancaster, all three of the gymnasiums were filled with triple bunks and each housed between 150 and 200 prisoners. Other housing units had 40 double bunks on the dayroom floor. CIT is using three units as dormitories filled with 200 prisoners in double-bunks. And at Corcoran a gym was converted into a triple bunked dormitory, and inmates in a housing unit in the sensitive needs yard were overflowing on to the dayroom floor.

8. These overcrowded housing units are neither safe nor secure. The custodial staffing in each of these units is not sufficient to provide adequate [4] supervision, especially because the bunks obstruct lines of sight and there are not enough officers to patrol the units. At Lancaster, for example, a gym housing reception center was filled with inmates that according to the Correctional Officer had not been classified by security level. This allowed prisoners with different potential for violence to be mixed in a housing unit where there was scant ability to provide supervision. This practice violates the most basic correctional practices designed to ensure that prisoners are safe from harm by other prisoners and that correctional officers are able to provide assistance if the prisoner has a health issue.

9. Adding to the risk of harm is the fact that these units are very hot, with the outside temperature between 95-102 degrees. Further, the prisoners had virtually nothing to do for months and sometimes years on end. The staff in these units confirmed that with the exception of the "E" Dorm at South at CTF there was little program or activity for these prisoners except exercise, and that was often cancelled because of the lack of officers or security lockdowns. At OT North, for example, the size of the housing units, coupled with the lack of recreational space, has resulted in a yard program that divides the yard between three housing units on one yard and two on the other yard. Limiting the number of inmates on the yard has reduced the potential for violence on the yard but has dramatically reduced the number of hours general population inmates are out of their cell. I was told over 50% of the inmates did not have education or work assignments. For these inmates the amount of out of cell time was slightly more [5]

than an inmate in administrative segregation or a security housing unit. As a former correctional officer and Warden, I have observed that prolonged periods of idleness under cramped conditions breeds anger and frustration. I also observed a growing number of elderly inmates at CTF central utilizing assistive devices such as a cane climbing grated stairs to get to their cell. These inmates were having some difficulty. This appeared dangerous under normal conditions. It is hard to imagine how they would accomplish this task in an emergency evacuation. There appears to be an insufficient number of first floor cells to meet the needs of the growing number of elder inmates. Inmates are often left with the choice of staying at a prison that has mobility challenges but offers some programs, such as CTF Central, or transferring to a prison that can meet their physical needs but has no or limited program availability. I agree with Governor Schwarzenegger that this level of overcrowding constitutes an emergency because it increases the risk of violence, riot and the transmission of infectious disease.

C. Reception Centers

10. It is also apparent that the sheer numbers of prisoners are straining the prison operations beyond the breaking point. This is especially apparent in reception centers. Several managers, including the Warded at Lancaster, remarked on the difficulty that they had keeping up with the flow of 1,000 newly arriving prisoners each month, each of whom must undergo a medical, dental and mental health examination. The reception center was also taxed by the need to keep inmates moving through the reception center until transferring to other prisons to [6] complete their sentence. It was also clear from touring

this facility that staff had difficulty keeping up with sanitation and cleanliness. Much of the prison, including medical examining rooms, was unbelievable dirty, lacking appropriate sanitation practices.

11. Another manifestation of crowding is the length of time it takes to transfer prisoners from the reception center to other prisons. Prisoners should be processed through a reception center in 60.days. At Lancaster, the Warden initially told us that the average length of stay was 113 days. During the tour, I was told by correctional staff that the average reception stay was about 120 days. I was later informed by the associate warden that the average length of stay was about 61 days, a figure which appears suspect.

12. The Warden acknowledged that some reception prisoners stayed at Lancaster for up to two years because there was no other place to put them. I spoke with one such prisoner in the most restrictive and harsh unit at the prison, the new free-standing administrative segregation unit. He had been in ASU for two years because there was no room for him at the security housing unit, and in the year since his disciplinary term had expired seven proposed transfers had failed. Since I only talked with a few randomly-selected prisoners in this unit, I am confident that a full examination of the 175 prisoners in that unit would have revealed similar cases. The situation was similar at CTF with at least one prisoner spending two years in administrative segregation because there was no place else to put him.

[7] 13. The Health Care Manager and Director of Nursing at Lancaster both remarked that prisoners coming into the prison from the county jails were sicker and had more medical and mental health problems than general population prisoners. The

chief medical records officer stated that the prison was two months behind in filing certain medical documents because files had not arrived from the *Plata* central medical records storage facility. This was particularly serious because virtually none of the prisoners from the Los Angeles county jails arrived with any health related information.

14. Although CTF is not a reception center, the mental health staff there stated that at times they felt like it was one. Not only were the absolute number (900) of outpatient (CCCMS) prisoners stretching their resources beyond their capability, but many CCCMS prisoners were present at the prison for only a short time, thus requiring staff to use their resources on the time intensive intake process. Mental health staff reported that they have had up to 200 new arrivals in a week, preventing them from .completing the initial evaluations within the timelines, even with staff working overtime.

D. Segregation Units

15. The Warden of Lancaster remarked that the reception center Enhanced Outpatient Program (EOP) prisoners were "really hurting us." Sixty percent of the EOP prisoners at Lancaster were from the reception center. Many of those were housed in an EOP administrative segregation unit. The unit was supposed to house only 54 prisoners, but had housed up to 90. The unit was noisy, filthy, and [8] there were cages all over the dayroom floor that were used as holding cells or for "group treatment". The Health Care Manager candidly acknowledged what was obvious—there was not enough room in the unit to provide medical and mental health treatment to all these mentally ill prisoners: I talked with several who were clearly very distressed. The prison had

converted some custodial office space to treatment space, but those rooms did not even have an examination table for medical staff

16. Prisoners in this EOP unit were not receiving the required ten hours per week of exercise. I examined CDCR forms 114-A, which covered the period of August 3 through 7, 2008. These forms are kept to record the services provided to prisoners in a segregation unit. In all of the thirty-nine 114-A's that I examined only one indicated that the prisoner had received exercise on one occasion. The others either indicated that the prisoner had refused or there was no indication that the prisoner was given the opportunity to exercise. I was quite surprised by the number of refusals since generally prisoners exercise when given the opportunity. The high number of refusals is a symptom of a problem that was not understood or being addressed by staff.

17. According to the Coleman requirements, a psychiatric technician is supposed to make rounds in the unit every day to identify prisoners at risk of decompensation or suicide. The 114s that I reviewed showed that the psych tech was making rounds only once every other day.

[9] 18. The sheer number of reception center prisoners caused prisoners to be housed in places that were completely inappropriate. In the recently built free standing administrative segregation unit at Lancaster, I talked to two minimum security prisoners who were in that unit only because there was no space anywhere else in the facility. The rules of the unit require all prisoners housed there to be treated the same. As a consequence, they remained in the cells for all but 10 hours a week, during which they could exercise in a small cage outside. Another pris-

oner was housed in this unit only because he had a relative who worked at the prison. When I brought these cases to the attention of staff, they told me arrangements had been made to have the minimum custody inmates moved out of the unit and they would explore the possibility of moving the inmate who had a relative working at the facility to another reception center. These examples are significant because it shows that this degree of overcrowding causes staff to make housing decisions solely on the basis of available beds and not according to the prisoners or the prison's needs.

19. While inspecting the administrative segregation unit at Corcoran, I saw a notice posted outside the cell that said that this prisoner had not received any property because he refused a cell mate. The light was off in the middle of the day and the prisoner was lying on his back on the floor motionless with a towel or cloth of some type partially covering his face. This atypical behavior strongly suggests that the prisoner is mentally or emotionally at risk. However, his condition apparently went unnoticed. A review of the 114-Ds for this prisoner [10] revealed that psych tech rounds were done daily, yet no one had referred this man for a psychiatric evaluation despite the behavior and lack of program participation noted on the CDC 114A until I pointed out his condition to the chief psychologist who accompanied me during the tour.

20. I interviewed an older prisoner housed in the Security Housing Unit (CDCR's most restrictive setting) at Corcoran who uses a wheelchair and was wearing a neck brace. After a few minutes, this man started talking about the electrodes that were emanating from his feet and that correctional officers were trying to kill him. It was obvious to me that this

man was out of touch with reality, and the Chief Psychologist who interviewed him shortly after me confirmed that he was severely psychotic. The Chief Psychologist said he was recently in a crisis bed for eight days, and had been in the SHU for the last thirty days. The Chief Psychologist said that he would be referred for a mental health evaluation, but that since he was refusing medication there was little they would do for him until he becomes a danger to himself or others by attempting suicide or assaulting another person. This was not an isolated incident. The Chief Psychologist noted that there were a lot of others like him in the SHU at Corcoran.

21. At Lancaster, I spoke with several of the prisoners in an EOP unit who appeared to be losing touch with reality. They had difficulty expressing their thought and appeared somewhat disorientated to time and space.

E. Lockdowns

[11] 22. Lockdowns continue to be common and were present at each of the prisons I visited. At CTF, the North facility had been on lockdown for about a month prior to the visit. Officers from other facilities had to leave their assigned posts and help with cell searches at North, leaving only one officer responsible for three tiers and hundreds of prisoners in each of the other units.

23. At Corcoran, one of the yards was locked down because of problems with one of the gangs. These lockdowns directly interfered with treatment because mental health staff were required to conduct interviews at the cell front, where there is no privacy.

24. At Lancaster, although the Warden said the prison had few lockdowns, it appeared much of the

prison was on some form of lockdown when we visited. There were few prisoners on the yards, and many prisoners and staff reported that prisoners had gone weeks or months without access to the exercise yard,

F. Custodial Staffing

25. In prisons custody staff is essential to providing prisoners access to health care services, especially in cases where prisoners need urgent or emergency treatment. Not only do they provide escorts at certain times, but they are responsible for alerting health care staff when prisoners complain of an immediate serious problem and also are supposed to observe prisoners periodically to identify actual or potential problems. It is essential to the well-being of prisoners that correctional officers perform these functions at all times. There is not enough custodial staff to keep prisoners safe from harm in California prisons today. [12] "System-wide, CDCR lacks the custody staff and organizational structure and processes to ensure that patient-inmates are reliably escorted and/or transported to medical appointments. As a result, patient-inmates are often denied timely access to health care services, substantially increasing the risk that patient-inmates' health will further deteriorate and increasing the overall costs of providing health care services." Exhibit 1 to joint Pls Trial Ex. 56 (Federal Receiver's Turnaround Plan of Action, attached as Exhibit 1 to Receiver's Eighth Report) at 5.

26. As noted above, in some facilities at CTF there was only one officer responsible for all prisoners in a housing unit. At Lancaster, correctional staff informed us that the day before we arrived, there were no officers on the floor in some units. That left only two officers in the control booth to observe the entire unit,

making in-cell observation and interaction all but impossible.

G. Space

27. I agree with the Receiver that space represents a serious obstacle to the delivery of health care. Joint Pls Trial Ex. 56 (Receiver's Eighth Report) at 5. The staff at all three prisons I toured complained about inadequate space. At CIT, the medical staff stated that the Receiver has accepted their proposal for the construction of more space, which they believed was "critical" to their ability to provide care, but the completion of that project is at least two years away. The lack of space is having an immediate impact since they have identified a physician who could provide services, but they don't have space for him. In the South facility at CTF the clinic is by any measure too small and crowded with staff who [13] hardly can find a place to sit. The infirmary at CTF had 16 beds, six or seven of which were occupied by prisoners who needed long term care. Staff said that they need double that amount.

28. At Lancaster, prison officials cannibalized general population libraries to make room for clinics. But, that resulted in law libraries being moved to the dayroom floor in some of the units, making that space unavailable for recreation and treatment. The medical records office does not have room for all the files; instead, only the current volume of the medical record was readily available. The records office staff were crowded into an extremely small space, and in a small hallway at the rear of the office, boxes filled with records were stacked against the wall, and other vacant boxes were stacked about 10 feet high.

29. The Receiving and Release area at Lancaster was not designed for that purpose. Consequently,

prisoners were stuffed into large holding cages where they spent up to ten hours with some sitting on the floor, waiting to be processed. The area used for psychiatric screening did not provide any visual or audio privacy. Prisoners and clinicians were sitting right next to each other in cubicles where the walls were about three feet tall. The Health Care Manager recognized the critical need for space, but was told it would be many years before the problems are alleviated.

30. As the Receiver noted recently, "The facilities available for providing health care services within CDCR are woefully inadequate. Through years of neglect, the facilities have long since passed the time when modest investments [14] could remedy the problem. We are dealing not with deferred maintenance, but with some facilities that are literally falling apart. In addition, investments in health care facilities have significantly lagged behind growing inmate populations, so much so that available clinical space is less than half of what is necessary for daily operations." Exhibit 1 to Joint Pls Trial Ex. 56 (Federal Receiver's Turnaround Plan of Action, attached as Exhibit 1 to Receiver's Eighth Report) at 25. "Simply stated, before constitutionally adequate health care can be delivered in California's prisons, there needs to be *constitutionally adequate treatment facilities to provide such care*. Unless and until the facilities are constructed, . . . prisoners will continue to die unnecessarily." Joint Pls Trial Ex. 56 (Receiver's Eighth Report) at 46 (emphasis in Original).

H. Conclusion

31. Overcrowding in the CDCR is extreme, its effects are pervasive and it is preventing the Department

from providing adequate mental and medical health care to prisoners.

32. The prison population can be reduced safely. As the former Chief Probation Officer of San Francisco, Warden of San Quentin and acting Secretary of the CDCR, it has been my experience that California incarcerates many more prisoners than is necessary for the safety of the public. This is not to say that offenders should not be held accountable for their actions. Sanctions other than incarceration are effective in punishing many prisoners and at the same time reducing the risk of recidivism. If California used these sanctions it would have [15] not only a prison system that is capable of providing essential services, but safer communities.

August 15, 2008

/s/ JEANNE WOODFORD
JEANNE WOODFORD

[1] REPORT OF JEANNE WOODFORD

No. CIV S-90-0520 LKK JFM P

COLEMAN

v.

SCHWARZENEGGER *et. al.*,

No. C01-1351 THE

PLATA

v.

SCHWARZENEGGER *et. al.*,

THREE-JUDGE COURT

NOVEMBER 9, 2007

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[1] *Plata v. Schwarzenegger*; *Coleman v. Schwarzenegger*

REPORT OF JEANNE WOODFORD

A. Background and Introduction

1. I received my B.A. from Sonoma State University in 1978. I became a correctional officer at San Quentin in 1978. I worked for the California Department of Corrections and Rehabilitation (CDCR) for the next 27 years in various custodial and management positions. While at San Quentin, I rose through the ranks, eventually becoming the Warden from 1999 to 2004. In 2004 Governor Schwarzenegger appointed me as the Director of what was then the Department of Corrections. In 2005 he appointed me to be the Undersecretary for the CDCR and then the acting Secretary of the Department. I retired from the CDCR in July of last year. Since November 1, 2006, I have been the Chief Probation Officer for the City and County of San Francisco. A complete description of my educational and employment background is set forth in my resume, which is attached as Appendix A.

2. All of my positions with the CDCR have included health care related tasks. While a correctional officer, one of my responsibilities was to escort prisoners to their medical or mental health appointments. As a supervisor in housing units, I was responsible for ensuring that correctional officers did the same. As a correctional counselor, I advocated for prisoners to be examined by physicians. As a manager at San Quentin and the CDCR I worked with health care staff, and court appointed personnel on the improvement of the health care delivery system both at San Quentin

and in the Department generally through both *Coleman* and *Plata*.

[2] 3. I have been asked by attorneys for the Plaintiffs in both of these cases to describe my observations of the effects of overcrowding on the delivery of medical and mental health care to prisoners and whether in my opinion overcrowding is the primary cause of the constitutional violations, and, if so, whether other orders would effectively address the severe problems that plague the CDCR. I agreed to describe my observations and express my opinions, but I will not accept any compensation for doing so.

4. In preparation for this report I have reviewed the following documents: Governor Schwarzenegger, *Prison Overcrowding State of Emergency Proclamation* (October 2006); Office of Inspector General, *Special Review into the California Department of Corrections and Rehabilitation's Release of Inmate Scott Thomas* (October 2007); Little Hoover Commission, *Solving California's Corrections Crisis: Time is Running Out* (January 2007); Assembly Bill 900; *Toussaint v. McCarthy*, 597 F. Supp. 1388 (N.D. Cal. 1984); CDCR, *Fall Adult Population Projections* (October 2007); Office of the Inspector General, *Special Review into In-Prison Substance Abuse Programs Managed by the California Department of Corrections and Rehabilitation* (February 2007); Expert Panel, *A Roadmap for Effective Offender Programming in California* (June 2007).

5. In the last four years I have testified as an expert witness in a trial involving death row in Ohio.

6. My observations are set forth below. My opinion is that overcrowding is the primary cause of the constitutional violations, and nothing short of a

reduction in the [3] prison population will effectively address these issues.

B. Causes and Effects of Overcrowding

7. When I began employment as a correctional officer there were fewer than 30,000 prisoners in 12 state prisons. In the early 1980s, the prison population began to grow, and as a result the then existing prisons, including San Quentin, began to increase the use of double ceiling, to house prisoners. I saw first hand the effects of overcrowding on prisoners, staff and the prison's infrastructure.

8. The increase in the prison population created problems in virtually all areas. Overcrowding caused the prison to be more dangerous for both prisoners and staff The environmental conditions deteriorated to the point where they posed health and safety risks to everyone living and working in some housing units. Violence increased among prisoners, putting prisoners and staff at a greater risk of harm. Crowding also put a tremendous strain on the prison's ability to deliver adequate services, particularly medical and mental health care to prisoners.

9. It was not long before lawsuits were filed, challenging these terrible conditions. Two cases, *Wilson v. Deukmejian* and *Toussaint v. McCarthy*, resulted in orders not to double cell prisoners. Another case, *Marin v. Rushen*, was settled with an agreement to provide enhanced medical and mental health services to prisoners. In the *Toussaint* case, the Court found that overcrowding "strains all environmental systems within the institution, and makes it difficult to provide decent conditions of confinement to lockup inmates." *Toussaint v. McCarthy*, 597 F. Supp. at 1405. I agree, although I believe the [4]

Court understated the challenges posed by severe overcrowding, perhaps because the lockup units at that time were only 140% overcrowded.

10. Overcrowding of the magnitude currently existing in the CDCR is unprecedented in my experience. I do not know of another state prison system that approaches this level of crowding. In my opinion, it is all but impossible to safely and humanely incarcerate this many prisoners within the existing facilities.

11. Management. The CDCR lacks an effective management structure, it has insufficient management information systems to provide accurate data to managers, and it lacks sufficient number of personnel who have the necessary skill and training to manage such a large and complex organization.

12. Overcrowding exacerbates the weaknesses in the organizational structure of the CDCR. There are simply too many issues that arise from such a large number of prisoners and staff. One result of this is that management spends virtually all of its time fighting fires instead of engaging in thoughtful decision-making and planning. This results in short-sighted decisions that create even more crises. Under these circumstances, it is virtually impossible for the organization to develop, much less implement, a plan to provide prisoners with adequate care.

13. Transfers/Classification. Overcrowding limits the CDCR's ability to get prisoners to the right prison for treatment. The health care needs of prisoners do not take place in a vacuum. The CDCR employs an objective classification system that assigns prisoners points based on the length of their sentence, their disciplinary history and other [5] objective factors.

Based on the number of points, prisoners are classified into one of four levels. The level of classification determines which prisons prisoners can be transferred to. In addition, many prisoners have other special needs, such as for protective custody, gang association or dual diagnosis. All of these factors limit the places that prisoners can be housed. Since crowding fills any available space, there is insufficient flexibility in moving prisoners so that their health care and other needs can be met. For example, crowding causes delays in moving reception center prisoners to other prisons for treatment. Instead, many parole violators end up serving their entire sentence in reception centers, which are not designed for, nor capable of, providing the appropriate treatment.

14. To manage the movement of prisoners appropriately, five percent of housing should be vacant. Without the flexibility that this vacancy rate provides, it is very difficult to ensure that prisoners are housed appropriately for their medical and mental health needs.

15. Staffing. A prison cannot function without adequate custodial staff. Custodial staff are essential to providing health care to prisoners because they supervise prisoner movement to and from medical .appointments, they escort prisoners to services within an institution and they provide supervision when prisoners are taken out of the prison to medical appointments, hospitals or they are transferred to another institution. In California there is not enough correctional staff to provide prisoners with timely access to care and still perform other essential functions.

[6] 16. Despite relatively high salaries, it is difficult to recruit enough correctional officers. While I was in the central office, we tried to step up recruitment efforts but we could not get enough applicants that passed the security and background checks and then made it through the academy to fill all our authorized positions. At San Quentin, for example, even when new recruits were added the effect was often temporary because after a short time correctional officers transferred to other prisons in more desirable, less expensive locations. In addition, the least experienced staff would often have to work the most difficult positions because union rules permitted personnel to bid on 70% of the open positions. When I visited the Correctional Training Facility at Soledad, for example, I found a lone correctional officer in a housing unit who told me that he could not search cells (a basic safety requirement) while prisoners were in the housing unit. When I asked what his supervising sergeant thought about this, he responded that there was no sergeant because it was the least desirable of the units at CTF.

17. The number of authorized positions is grossly inadequate to provide sufficient staff to meet all of the prisoners' basic needs. For example, there are often only two officers to supervise 200 prisoners in a gym or a dorm. This is extremely dangerous for both the prisoners and the staff because line of sight supervision is impossible under these circumstances and it does not permit the staff the time to recognize that prisoners are in trouble from any number of causes, including medical or mental illnesses.

18. Inadequate staff has created dangerous conditions for both the staff and prisoners. To be effective, correctional officers must interact with prisoners.

This [7] communication reduces tension and violence in the unit, and it often allows the staff to know when a prisoner has a medical or mental health issue. Generally, there is not enough prisoner-staff interaction in the CDCR because of the staffing shortages and the insufficient number of staff positions in many of the housing units.

19. The danger to prisoners is enhanced because the correctional staff frequently is forced to work mandatory overtime. Some staff work back-to-back double shifts and would sleep in their cars in the prison parking lot instead of making the long commute home. Officers who are tired and suffer from low morale are often less productive and do not fulfill all their responsibilities to provide for the basic needs of prisoners. Such officers will be less responsive to prisoners who need escorts to medical or mental health services and will be less likely to recognize signs and symptoms of mental illness or manifestations of suicidal ideation.

20. At Corcoran and SATF two tragic cases illustrated the problem. One prisoner literally starved to death and another bled to death. Many officers were in the unit at the time these events occurred. It is inconceivable to me that officers who were properly supervising the prisoners in their care would not notice such obvious events.

21. The tragic effects of overcrowding reach into the community. The case of Scott Thomas exemplifies the unreasonable demands placed on staff when the prisons are so overcrowded. Scott Thomas was mistakenly released on parole on May 18, 2007 and allegedly entered a San Francisco bakery and stabbed a 15 year-old girl and a man who came to her aid.

[8] 22. San Quentin staff made three fundamental errors when processing this case. First, they confused Scott Thomas with another prisoner, Steve Thomas, who was a different race, 16 years younger and 40 pounds lighter. Second, in 2002 the CDCR designated Thomas as "high control", which requires the Department to take additional precautions, such as close supervision, when releasing such prisoners on parole. No such precautions were taken despite prominent documents to that effect in his prison file. Third, staff violated clear CDCR policy that required the release of a prisoner serving a term in the security housing unit directly to a parole agent.

23. Although it is clear that individuals did not comply with CDCR policy, the inappropriate release of Thomas is really a system failure because the people doing the work have an impossible mission. Having been a correctional counselor with similar responsibilities, I know from first hand experience that there is not enough time for the Correctional Counselor III to review 150 to 200 cases per week and do their job properly. Nor is there sufficient trained records staff to complete adequate review of cases for parole or other legal releases.

24. Lockdowns. Lockdowns exacerbate the overcrowding crisis because they are staff intensive and inhibit the delivery of services to prisoners. When I became the Director I was shocked by the number and durations of lockdowns. A recent state-sponsored study of lockdowns recognized the direct relationship between overcrowding and lockdowns: the "other side of the overcrowding coin is that when wardens implement security lockdowns, they usually shut down all programming in the affected areas. Not [9] only is this disruptive to programming but, the Panel

believes the number and duration of lockdowns in California prisons is excessive." Expert Panel, *A Roadmap for Effective Offender Programming in California*, at viii.

25. Lockdowns make the delivery of medical and mental health particularly difficult because staff must escort prisoners to every service or bring the service to them. The CDCR prisons are not staffed for that. In my experience, mental health services were at times cancelled because of lockdowns or other emergencies, and officers would only escort prisoners with urgent medical conditions.

26. Lockdowns increase the risk that a prisoner will not get treatment in an emergency because prisoners are dependent on the correctional officer to properly convey the medical problem to medical staff and then be able get an escort to the clinic. Conversely, there is an extra burden on medical staff because they may be required to travel to the housing unit.

27. Lockdowns also adversely affect some prisoners' mental health. I have observed many prisoners who have been locked in their cells for long periods of time deteriorate right before my eyes. Their skin becomes ashen, their ability to communicate is reduced and sometimes they are not oriented to time and place.

28. Clinical Space. California's prisons were not built with sufficient space for medical and mental health services. Space for mental health facilities is a particular concern because of all the activities that are required by the *Coleman* program guides. To meet the demands for space the CDCR was constantly trying to shoehorn mental health [10]

facilities into areas that were not designed for such activities. Not only did this make an imperfect fit for the space, but it also resulted in the loss of space for other programs.

29. Old and Deteriorating Prisons. Many of the existing facilities are too old and decrepit to provide humane housing. Among those include parts of the Correctional Training Facility, Deuel Vocational Institution, San Quentin, the California Mens Colony, Folsom, the California Rehabilitation Center and the Correctional Conservation Center.

30. When I visited prisons during my tenure as Director at times the noise levels were so bad that it was enough to drive a sane person crazy. In some units, like Palm Hall for example, staff found it unbearable to remain inside the unit for more than a few minutes.

C. The State's Inadequate Response to Overcrowding: AB 900.

31. Assembly Bill 900 is not the right solution for the overcrowding crisis. AB 900 essentially is a prison expansion measure which increases the number of prison cells without addressing the fundamental structural issues that have caused the crisis and that have created unconstitutional conditions within the prisons. It is not consistent with the recommendations of the report of the Expert Panel on Corrections Reform as well as other similar reports. *See* Expert Panel Report at 77 (summarizing recommendations of previous reports).

32. AB 900 does nothing to limit the growth of the prison population. According to the CDCR's latest projections, the population will increase by another 10,000 prisoners [11] by 2010. This confirms my

belief that California cannot build its way out of this crisis.

33. AB 900 relies heavily on the assumption that there will be a reduction in recidivism through rehabilitative programs in the planned reentry facilities. That assumption is wrong. CDCR paroles 10,000 prisoners per month. Sixty percent of those parolees serve an average of 4.5 months, and 69% of first time parolees serve less than a year. Not only is this precious little time to promote effective rehabilitation, but I agree with the Little Hoover Commission that these "short prison stints" have no effect on public safety. "[T]hey . . . disrupt families and communities where these offenders come from and return to, and diminish the potential for offenders to get and keep jobs, maintain housing and become law-abiding citizens." Little Hoover Commission, *Solving California's Corrections Crisis*, at 27.

34. Effective rehabilitation assumes that the Legislature and Governor will appropriate enough money for effective programs. This fiscal year the legislature enhanced the budget for programs by only approximately $50 million. By any measure, this paltry figure demonstrates a lack of commitment to rehabilitation in a system this large with an annual budget of almost $10 billion. In my experience, in tight fiscal times the first thing to go in corrections is money for rehabilitative programs.

35. I witnessed the destruction of most rehabilitation programs during the early 1990s, from which the department has never recovered. With a California budget deficit expected to reach over $8 billion next year, I do not believe that the state legislature's monetary commitment will be any greater and probably much less.

[12] 36. AB 900 relies heavily on the construction of 32 reentry facilities located in urban areas to provide rehabilitation. Since many, if not most, of the prisoners will spend only a short time in these facilities, I doubt it will be very effective in reducing recidivism. In addition, it is extremely unlikely that the CDCR will be able to site 32 of these facilities in local communities, especially in urban centers.

37. In the unlikely event that these facilities are built. I question whether they will ever be adequately staffed or managed. Since the CDCR cannot effectively manage or staff its existing 33 prisons, doubling the number of prisons will only aggravate the problems.

38. The Inspector General recently audited the substance abuse treatment provided by the CDCR. He concluded that the effort was all billion failure-failure to provide an environment that would allow the programs to work; failure to provide an effective treatment model; failure to ensure that the best contractors are chosen to do the job at the lowest possible price; failure to oversee the contractors to make sure they provide the services they agree to provide; failure to exert the fiscal controls necessary to protect public funds; failure to learn from and correct mistakes-and most tragically, failure to help California inmates change their lives and, in so doing, make our streets safer." Office of the Inspector General, *Special Review into In-Prison Substance Abuse Programs Managed by the California Department of Corrections and Rehabilitation*, at 5. Nothing that I now know suggests that the CDCR is any more capable of reducing recidivism through these or any other programs. In fact my experience with the [13] leadership of the CDCR suggests the opposite. When

I was the Acting Secretary of the CDCR, I adopted a goal of reducing the recidivism rate by 10% by 2010. When I stepped down from this position that goal was rescinded. The Secretary informed me that he had rescinded that goal because he believed it was risky to set such a goal. Throughout my career I have found the leadership unwilling to be accountable for the outcome of prisoner programs.

39. The so-called "in-fill" beds will cause more problems than they will solve. Many of California's prisons are so big that they are effectively unmanageable. Wardens and other administrators spend much of their time responding to crises, rather than fulfilling their responsibilities to provide adequate medical and mental health care. Unless these in-fill beds stand alone with their own administrative and support facilities, adding thousands of additional prisoners to already overburdened facilities will only compound the burdens imposed on prison administrators and line staff.

D. Communications with the Governor and His Staff on Overcrowding

40. When the Governor offered to appoint me as acting Secretary of the CDCR, asked him whether we could meet to discuss the direction that I wanted to pursue for the Department. He agreed to meet the next week, but despite several attempts, I never met with him again until the day I resigned.

41. I wanted to meet with the Governor to make sure that I would have his support for the initiatives I believed were necessary. I particularly wanted to talk to him about sentencing reform because I believed that the population pressures were going to

[15] continue and that the state could not build its way out of this problem.

42. I did subsequently meet with Ms. Kennedy, the Governor's Chief of Staff, and Fred Aguiar, the Governor's Cabinet Secretary, and informed them that I could not accept the position as Secretary until I had an opportunity to discuss my plans with the Governor. I told them about the population pressures and my position on sentencing reform. Ms. Kennedy said that she wanted to give the issue some thought, but never discussed this issue with me again until the day I resigned.

43. I finally met with the Governor in his smoking tent after I told Mr. Aguiar that I planned to resign. I told the Governor that the state did not have a plan to address the population pressures. In a prior meeting with the Governor as the Undersecretary of the CDCR the Governor asked me if I thought we needed more prison beds. I replied no, unless it is to replace existing capacity. I explained that California has more prisoners than Texas, yet Texas has over one hundred prisons and California has only 33. I informed the Governor that California had built very' large prisons that were designed to warehouse inmates. These large prisons are very difficult to manage and do not provide enough space for programs and services.

44. During my meeting with him on the day I stepped down as acting Secretary of the CDCR I explained that we could not build our way out of the overcrowding problem and that we needed sentencing reform. I also explained to him that we parole about 70,000 parole violators per year who serve twelve months or less and that this revolving door created population pressures. I also told him that dangerous

offenders were being [15] released without any treatment or program, and that this crisis was jeopardizing public safety. In addition, I explained that low level offenders could receive programs in the community that would cost less and he more effective than the prison programs. Governor Schwarzenegger said that this all sounded reasonable. but Ms. Kennedy reminded him that it was an election year and the meeting ended shortly thereafter.

45. It was obvious to me at that time that in order to run an organization this large with such complex, high profile problems, the CDCR Secretary must have meaningful access to and the support of the Chief Executive. He is the only one who can make the tough, politically sensitive decisions that are necessary to alleviate the crisis. Since it was obvious that I was not going to have this necessary access and it was evident to me the Governor was not going to address the issues in a way I thought would address the prison overcrowding problem, I resigned my position as acting Secretary.

E. Conclusion

46. The Governor's October 4, 2006 emergency proclamation recognized that California's prisons are severely overcrowded, creating "extreme peril" to the health and safety of prisoners and that "the magnitude of the circumstances exceeds the capabilities of the services, personnel, equipment, and facilities. . . ." I agree. Until the population is reduced substantially there is no realistic hope that the unconstitutional conditions will be eliminated.

Dated: November 9, 2007

/s/ Jeanne Woodford
Jeanne Woodford

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF CALIFORNIA AND THE
NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. 2:90-cv-00520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TRIAL AFFIDAVIT OF ROBIN DEZEMBER

To: Three-Judge Panel

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[1] I, Robin Dezember, declare:

1. I am employed by the California Department of Corrections and Rehabilitation in the position of Chief Deputy Secretary of Health Care Services within the Division of Correctional Health Care Services. I offer this written testimony on the delivery of mental health care services within the California Department of Corrections and Rehabilitation in light of the Plaintiffs' request for a prisoner release order to address the alleged overcrowding of the CDCR population.

2. I have personal knowledge of the facts stated in this declaration and, if called to testify upon those facts would do so competently.

I. *Current Position and Background*

3. Before I started my career, obtained a bachelors degree from Arizona State University in 1966, and proceeded to achieve a juris doctorate degree from the University of California, Hastings College of Law in 1969.

4. I have served government agencies in a variety of management positions for over thirty-five years. I am a fellow with the National Commission on Correctional Healthcare. I have been a member of the faculty of the Graduate School of Criminal Justice at Sacramento State University and the Graduate School of Public Administration at Golden Gate University.

5. As Chief Deputy Secretary of Health Care Services since January, 2007, I am responsible for developing the administrative structure to support, at the least, a constitutionally adequate mental health care system and dental care delivery system. I have reorganized and expanded the central and regional administrative

structures necessary for supporting the growth and maintenance of appropriate care of inmates within CDCR.

6. My work as Chief Deputy Secretary draws upon the experience gained in a lengthy career dedicated to serving government agencies. That career has included the following positions, in brief:

a. I was the Executive Officer and Chief Hearing Representative for the [2] California Board of Prison Terms from 1976 to 1982, responsible for the management of all aspects of the Parole Board's operations, including budgets, personnel, policy development and due process hearings.

b. I was the Undersecretary of the California Youth and Adult Correctional Agency from 1982 to 1986, an appointee of Governor Deukmejian. In that position, I was responsible for the overall administration of the Departments of Corrections and Youth Authority, Parole Board, and Board of Corrections. My tenure as Undersecretary dovetailed with the "boom" in prison construction. I created the New Prison Policy Committee and, as chairman, initiated the State's multi-billion dollar prison expansion program using public/private sector partnership for Program Management. I also established the first California Corrections Manager's Council comprised of selected representatives of state sheriffs, chief probation officers, and state juvenile and adult correctional agencies.

c. With the end of my tenure as Undersecretary, I left the public sector and joined the construction management firm of Kitchell, Inc. as Senior Vice President. From 1986 to 1993, I provided executive leadership for the firm's Program Management services, involving more than $5 billion in public capital expenditure projects for the further expansion of the California Department of Corrections.

d. In 1993, Governor Wilson appointed me Deputy Director and Assistant Chief Counsel of Health Care Services for the California Department of Corrections. In that position, I developed the policy, procedures, and organizational structure for creating a new comprehensive, standardized Health Care Delivery System based on managed care concepts. I initiated strategic planning and management for all health care services provided by 4,500 staff in 32 institutions throughout the state. I developed a remedial plan for and initiated implementation of a Mental Health Services Delivery System in response to the then-recent injunctive order in *Coleman v. Wilson*. I initiated final implementation of remedies that enabled termination of a class action brought by women prisoners for medical services, entitled *Shumate v. Wilson*, No. CIV [3] S-95-0619 (ED. Cal.).

e. After some 25 years of executive-level work, I returned to school and obtained a Masters degree in Health Services Management from Golden Gate University, San Francisco, in 1994.

f. In 1997, Governor Wilson appointed me Chief Deputy Director for Finance Policy within the California Department of Finance. I represented the Governor and the Director of Finance on more than 60 boards, commissions, and finance authorities. My position encompassed serving as Chair of the State Public Works Board, which governs the state's capital outlay process, and member of the California Health Facilities Finance Authority, which reviews and approve funding mechanisms for the development and expansion of private health care facilities.

g. In 1999, I joined Jacobs Facilities, Inc. as the Director of Government Programs. In this executive level position, I was responsible for program and management development for government capital programs in the Western Region within the public sector markets of corrections, justice, education and general public institutions.

h. I formed a private consulting firm, RJ Dezember Associates, in 2001, to provide consulting services on various issues of California state and local government. I also consulted with other government agencies, including the State of Pennsylvania, on their corrections systems.

i. In 2007, I rejoined CDCR in my present position.

II. *Overview*

7. I understand this Three-Judge Panel has been convened to address the issue of CDCR's overcrowding and its impact, if any, on the delivery of mental health care services to CDCR inmates.

8. Because of my tenure with CDCR, I am uniquely positioned to speak to the mental health care delivery system and its compliance with the *Coleman* court orders. I was employed as the Deputy Director and Assistant Chief Counsel of Health Care [4] Services within CDCR when the *Coleman* injunction issued in 1995. I have spent a good portion of my career collaborating with the *Coleman* Special Master to establish and meet mandates for mental health care and, more specifically, to meet the mentally ill inmates' need for mental health care services. Indeed, in 1995, J. Michael Keating, Jr. was appointed to serve as the special master in the *Coleman* case. I had already established a successful working relationship with him when he was appointed Special Master in the

Shumate case in 1997. With the termination of the *Shumate* case as an exemplar, I have worked towards the termination of the *Coleman* case.

9. I am familiar with the elements of a constitutionally adequate mental health care system, as stated in the published decision of *Coleman v. Wilson*, as well as the ensuing orders of that Court. I recognize that the trial court found CDCR violated the Eighth Amendment because CDCR showed deliberate indifference to the mental health needs of inmates. I submit that CDCR now demonstrates a consistent and integrated approach to the care of mentally ill inmates. That approach has been manifested in the development and implementation of established and systemic mechanisms to ensure the elements of a constitutionally compliant mental health care system—such as sufficient and appropriate beds, staff, medication management, record keeping, suicide prevention measures—are met today and continue to be met tomorrow.

10. By this declaration, I respectfully submit to the Three-Judge Panel information regarding the mental health services delivery system. Because my tenure with CDCR permits the benefit of a retrospective view, my discussion will often compare and contrast the state of the mental health services delivery system at time of judgment in 1995 to the state of the mental health services delivery system today. I will discuss the breadth of the mental health population and the spectrum of mental health care services provided to that population. I will also address the housing of the mentally ill inmates of CDCR.

[5] III. *CDCR Has an Integrated Multidisciplinary Approach To Inmates' Mental Health Care Needs*

11. The fundamental requirements of an adequate mental health service delivery system in CDCR center on a few primary elements that together form the basis for effective care. These elements are: (a) uniform policies and procedures for the delivery of mental health care; (b) appropriately licensed and credentialed clinical staff and support staff, both in the prisons and in central office headquarters, with sufficient number to perform their responsibilities; (c) appropriate space for the provision of mental health services to the inmate-patient population that can accommodate services of a growing population, especially for the higher treatment levels that require residential care; and (d) an adequate information management system for recordkeeping and medication management; and an adequate suicide prevention protocol. *See Coleman V. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

12. I would add another, overarching element to ensure a functional mental health care system continues to perform: a system of management within the prison setting that continually assesses routinely acquired service delivery information in terms of compliance with established process and performance indicators and, upon identifying issues of non-compliance, engages the processes necessary for their resolution. The management structure must be able to establish and rely on forecasts of the demand for services into a reasonable future time period and the development of plans to address this demand. These management elements have been initiated in the last two years.

13. Plans that should result from these forecasts would prepare for expanding the services delivery system, generate the resources necessary to meet the forecasted demand, and engage the entire spectrum of prison services, including mental health service delivery in an overall program of compliance with policies and procedures. It is necessary, however, for all of these management actions to function together for if one of them is missing the result will be unsatisfactory. With adequate management, the [6] mental health care services delivery system will better meet the needs of the mentally ill inmate and address identified deficiencies notwithstanding population growth.

IV. *Defendants Have Achieved Court-Approved Mental Health Care Policies and Procedures*

14. At the time the *Coleman* case was tried before Magistrate Moulds, CDCR lacked a uniform set of systemwide policies for identifying those individuals who have mental health care needs and providing that care. Magistrate Mould's Findings and Recommendations noted: "The CDC lacks an adequate mechanism for screening for mental illness, either at the time of reception or during incarceration, and has lacked adequate screening since at least 1987." (Defs.' Trial Ex. 1273 which is a true and correct copy of *Coleman* F&Rs, filed June 6, 1994, 31:10-20.) Neither standardized forms nor procedures for mental health screening existed. (*Id.* at 31:15-25.)

15. By the time the Court entered its decision in 1995, CDCR had already established a statewide mental health screening process with referrals for mental health treatment. In 1997, an initial set of policies and procedures (the "Program Guide") were

adopted by CDCR and provisionally approved by the *Coleman* Court.

16. That set of provisional policies matured into a final set of policies and procedures approved by the *Coleman* Court in March 2006. (*See* Defs.' Trial Ex. 1042 which is a true and correct copy of *Coleman* Court Order, filed 3/06; Defs' Trial Ex. 1147 which is a true and correct copy of the 2006 Program Guide.) This development of the 1997 provisional policies into the court-approved 2006 policies involved lengthy and laborious discussions of various draft policies, procedures and forms by a team of CDCR's top mental health clinicians with Plaintiffs' attorneys and the Special Master's team. The discussions occurred in day-long meetings and spanned over three years.

17. Through this process, Defendants were able to obtain consensus with the Special Master's team and Plaintiffs' counsel, as much as possible, on the very language of the policies, procedures, and forms stated in what became known as the Revised Program Guide.

[7] 18. I personally participated in many of these all-day negotiation sessions. I recall the Special Master stating that the Revised Program Guide provided for mental health care well beyond the mere requirements of a constitutionally adequate mental health care system under the Eighth Amendment. Based upon my work and expertise as an administrator of correctional health care, I agree that the Program Guide provides for the care of mentally ill inmates in a manner that comports with, if not exceeds, the Eighth Amendment and the care seen in correctional institutions in other states.

19. Compared to the provisionally approved Program Guide of 1997, the Revised Program Guide of 2006

provided for "enhanced standards for mental health care applicable in all CDCR institutions." (Defs.' Trial Ex. 1109 which is a true and correct copy of *Coleman* Special Master's 17th Report, Part A, filed May 4, 2007, internal pp. 3-4.)

20. The Program Guide provides for several different levels of care to meet different patient needs, as follows:

a. Correctional Clinical Case Management System (CCCMS): Inmates receiving this level of care are able to function well in the General Population with some mental health treatment. These inmate-patients are provided individual therapy at least once every 90 days, medication management by a psychiatrist at least once every 90 days, and group therapy as indicated by the, inmate-patient's treatment plan.

b. Enhanced Outpatient Program (EOP): Inmates receiving this level of care are segregated from the General Population in yards dedicated to these inmates because they require significant services to function well. These inmate-patients are provided weekly contact with a primary clinician, medication management by a psychiatrist at least once every 30 days, and structured treatment activities 10 hours per week.

c. Psychiatric Services Unit (PSU): The purpose of the PSU is to assure the effective delivery of EOP services to inmates who have been diagnosed as having a serious mental disorder and are serving a security housing unit term.

[8] d. Mental Health Crisis Beds: Inmates receive this level of care because of a short-term need for intensive mental health care services, generally not to exceed 10 days. This level of care provided 24-hour

inpatient care, evaluation, and treatment for inmate-patients who require mental health services to prevent danger to themselves or others, or who have mental conditions which cause grave disability.

e. Inpatient Non-Acute Intermediate Care Facility (ICF): Inmates receive this level of care because of a longer-term need for intensive mental health care services delivered by the Department of Mental Health (DMH).

f. Day Treatment Program: This program with 44 beds is operated by the DMH at the California Medical Facility. It is designed for patients needing transitional outpatient care, essentially a step down from intermediate to Enhanced Outpatient Program level of care.

g. Inpatient Acute Care: The Department of Mental Health delivers this 24-hour inpatient care in licensed facilities. Inmates who require mental health treatment to prevent danger to themselves or others, or who have mental conditions which cause grave disability (such as an inability to use food, clothing, or shelter in appropriate ways) receive individual and group therapy as well as medication management by a psychiatrist.

21. The 2006 Program Guide contains standardized mental health forms for screening and referring patients to appropriate levels of care, including subsets of the mental health population such as exhibitionists. (Defs' Trial Ex. 1146 which is a true and correct copy of Defs' Plan to Provide Care to Exhibitionists, July 2007 and August 2007.) The referrals of patients requiring inpatient intermediate and acute care beds are governed by a memorandum of understanding, revised every two years or so, between CDCR and

DMH for DMH to provide such inpatient mental health care to CDCR patients. The working partnership between CDCR and DMH for inpatient care has been enhanced by the use of Coordinated Clinical Assessment Teams to discuss, on a weekly basis, the merits of any decisions on referrals. (*See* Defs.' Trial Ex. 1274 which is a true [9] and correct copy of *Coleman* Order, July 9, 2004.) When DMH noticed some referred patients did not have a therapeutic level of psychotropic medications in their bloodstreams, CDCR responded by requiring blood reference value testing. (Defs.' Trial Ex. 1275 which is a true and correct copy of CDCR Memo, April 4, 2008.) As more fully discussed below, the CDCR-DMH partnership has also engendered the development of additional inpatient mental health care beds within existing prison sites.

22. The population of mental health care patients served by CDCR has expanded from the certified class of inmates with serious mental disorders certified as *Coleman* class members at the start of this case to include those parolees within the physical custody of CDCR who are awaiting parole revocation hearings and who meet *Coleman* care criteria. (*See* Defs.' Trial Ex. 1276 which is a true and correct copy of *Coleman* Order, filed August 8, 2008.) In accord with the *Coleman* court order merging these two populations, the CDCR-DMH memorandum of understanding as well as submitted draft plan to provide mental health care to these parolees acknowledges both of these populations as patients under the *Coleman* Program Guide standards. (Defs.' Trial Ex. 1193 which is a true and correct copy of *Coleman / Valdivia* Draft Mental Health Plan, Draft MOU, September 2008.)

23. This reliable and standard set of policies and procedures governing mental health service delivery has been disseminated to and implemented by CDCR and DMH clinicians. Training for clinical practitioners has occurred and will continue to occur regularly, especially with the adoption of any significant policy or procedure.

24. The Program Guide is now subject only to an annual revision process. This revision process enables the further development of mental health care policies in timely fashion, and takes into account the views of the *Coleman* Special Master, the Special Master's team of court-appointed monitors, Plaintiffs' attorneys, and, on certain overlapping issues between the medical and mental health care systems, the *Plata* Receiver. Indeed, the annual revision process to enable publication of the 2008 Revised Program Guide has occurred, with distribution of the draft 2008 Revised Program Guide [10] to Plaintiffs' counsel and the *Coleman* Special Master for review earlier this year and distribution of the final 2008 Revised Program Guide to the field in the offing. (Defs.' Trial Ex. 1148 which is a true and correct copy of the 2008 Revised Program Guide.)

25. The *Coleman* Special Master himself declared, as of this past year, that "several CDCR institutions were substantially compliant" with the Program Guide and court-ordered standards. (Defs.' Trial Ex. 1112 which is a true and correct copy of *Coleman* Special Master's 20th Report, filed September 12, 2008 at 6.)

26. In my opinion, CDCR has accomplished the establishment of an adequate mental health delivery system by preparing, distributing, training, and implementing the court-approved Program Guide since 2006.

V. *The CDCR Suicide Prevention Program Has Already Been Found Adequate*

27. Throughout the course of the *Coleman* case, Defendants have addressed the risk of suicide among inmates. Indeed, Defendants' suicide prevention measures were recognized and approved by the trial court in 1994.

28. Even as early as 1990, CDCR had a Suicide Prevention Program in place. (Defs.' Trial Ex. 1273 which is a true and correct copy of *Coleman* F & R, 71:3-5, and *cites therein*.) Indeed, the Suicide Prevention Program was "standardized and enhanced in 1990." (*Id.*) The program consisted of three major components: staff education, prevention, and assessment. (*Id.*, 71:5-7, and *cites therein*.)

a. Education of Correctional Officers: A suicide Prevention Handbook was published for in-service training for correctional officers. (Defs,' Trial Ex. 1273 which is a true and correct copy of *Coleman* F & R, 71:11-13, and *cites therein*.) Further, correctional officers received suicide prevention training as part of the curriculum at the Department of Corrections Training Academy and as part of their on-the-job training. (*Id.* at 71:11-23.)

b. Prevention: the Suicide Prevention Program enabled identification of inmates who are potential suicide risks and the placement of such individuals under 'suicide watch.' (*Id.* at 72:1-9.)

[11] c. Assessment: A psychological autopsy on each inmate who committed suicide was mandated by the Suicide Prevention Program. The autopsies included a "description of how the suicide was accomplished, as well as specific recommendations on how to prevent a similar occurrence and timelines for

implementation of the specific recommendations." (*Id.* at 72:10-17.) The psychological autopsy was sent to both CDCR Health Care Services and the warden of the institution where the suicide occurred in order to enable action upon its recommendations. (*Id.* at 72:17-21.)

29. In 1994, the trial court noted the decline in the CDCR suicide rate, from a high of 77 per 100,000 inmates in 1982 to 14 per 100,000 inmates in 1992. (Defs.' Trial Ex. 1273 which is a true and correct copy of *Coleman* F&R, 70:18-22.) Further, the suicide rate for male inmates in the CDC "appears to be lower than the rate in the general population; in 1992, the suicide rate for male inmates in the CDC was 14 per 100,000 inmates, while the rate for non-imprisoned males was 20 per 100,000." (*Id.* at 70:22-71:2.) The suicide rate for female inmates was "relatively low" with only 2 suicides committed by females of the 181 suicides that occurred within CDCR from 1980 to 1990. (*Id.* at 70, n. 45.)

30. The trial court specifically found "defendants have designed an adequate suicide prevention program and have taken many of the steps necessary to implement that program." (*Id.* at 75:1-6.) The full deployment of the 1990 Suicide Prevention Program was hindered only by the "severe understaffing in mental health care." (*Id.* at 75:4-6.)

31. Since the entry of judgment in 1995, Defendants have expanded the Suicide Prevention Program already declared adequate by the trial court and obtained sufficient staffing to enable its full implementation.

32. The Suicide Prevention Program now consists of a multi-faceted and multi-disciplinary approach to

preventing suicides. In other words, mental health clinicians, correctional officers, and facility management personnel are now involved in responding [12] to and preventing suicides in CDCR's inmate population.

33. Mental health clinicians receive direction on the prevention of suicides from several administrative sources. First, the 2006 Program Guide contains an entire chapter dedicated to delineating the identification of inmates at risk for suicide (whether already a patient within the Mental Health Services Delivery System or not) and the treatment of such inmates. The Program Guide provides a clear set of guidelines for screening inmates for the risk of suicide, with a uniform questionnaire used at reception centers and before placement into an administrative segregation unit. A range of responses to the individual inmate's suicide risk may be undertaken, from placement on suicide watch with one-to-one monitoring of the inmate to referral to a higher level of mental health care.

34. The Program Guide also informs the clinicians of their ability to access a *Coleman* class member's history of suicide attempts. In accord with the *Coleman* court order of June 9, 2005, CDCR has diligently worked to create a database within the Mental Health Tracking System to record *Coleman* class members' history of suicide attempts and gestures. The clinicians are responsible for ensuring a record of an inmate's history of attempted suicide, if any, is maintained and considered as part of the treatment protocol.

35. Within my organization and at my direction, mental health care clinicians receive in-service training on suicide prevention protocols. I have a designated Suicide Prevention and Response Coordinator for CDCR Health Care Services who designs and delivers

the suicide risk assessment training for CDCR's mental health clinicians. (*See also* Decl. Canning in Support Def. MIL No. 10, at ¶ 2.) Further, the Coordinator delivers a monthly suicide prevention videoconference for 300-350 CDCR clinical staff. (*Id.*)

36. At my direction, the psychological autopsies discussed in the *Coleman* trial court continue to this day, but in expanded form under the rubric "Suicide Report." (*See also* Decl. Canning in Support Defs.' Mot. In Limine No. 10, ¶ 4.) This report, prepared by a psychologist at CDCR Headquarters, addresses the suicides of individual inmates [13] that have occurred within the confines of CDCR. (*Id.*) In preparing these reports, the psychologist visits the facility where the suicide occurred, interviews available witnesses (such as cellmates, co-workers, housing officers, work supervisors) and mental health care providers, conducts reviews of the inmate's central files and unit health record (including any and all mental health records), reviews the reports of other investigators (such as the investigating officers' incident report, any coroner's report, medical death review reports), reviews visiting and telephone records, views personnel effects, and sometimes interviews family members. (*Id.*) Each Suicide Report provides a summary of the possible distal and proximal causes of the suicide, the victim's apparent mental health status before their death, any mental health care provided to the victim, the emergency response measures undertaken, and, as appropriate, recommendations concerning any deficient practices by correctional or clinical staff that may have contributed to a suicide (in accord with the January 12, 2004 *Coleman* court order). (*Id.* at ¶¶ 4, 5.) The Suicide Report assists in the development of any quality improvement plan, which must be submitted within 180 days of any suicide in accord with the

Coleman court order of June 13, 2002. (*Id.*) These Suicide Reports are analyzed in the preparation of an annual executive report on suicides presented to CDCR executives. (Defs.' Trial Ex. 1171 which is a true and correct, copy of the 2006 Annual Report on Suicides within CDCR.)

37. Correctional officers today continue to receive particular training on appropriate responses to suicide gestures and attempts by an inmate. As much as clinicians have an understanding of the mental health needs of an inmate, the correctional officers' ongoing work with the inmates enables an opportunity to become familiar with an inmate's daily habits and often life issues, such as "bad news" from court or the loss of a loved one. Correctional officers are now trained in identifying possible mental health issues and the means of referring an inmate for a mental health evaluation.

38. Because correctional officers are often the "first responders" at a suicide, [14] they are now responsible for providing life-saving cardiopulmonary resuscitation (CPR) to those inmates who have attempted suicide and show no obvious signs of demise. (*See* Defs.' Trial Ex. 1279 which is a true and correct copy of *Coleman* Order, June 9, 2005.) In 2006 and 2007, CDCR filed a proof of compliance with this court mandate, including declarations from each of the wardens of the 33 institutions attesting to the completion of CPR training (with the provision of cutdown kits and microshields for CPR) by the correctional officers within their employ. (*See* Defs.' Trial Ex. 1279 which is a true and correct copy of *Coleman* Order, June 9, 2005; Defs.' Trial Ex. 1280 which is a true and correct copy of *Coleman* Stipulated Order, February 13, 2006.) In addition, CDCR requires correctional officers to

complete a standard incident report detailing the reasons CPR was not undertaken in response to a suicide event. This uniform incident report is reviewed by the warden and by headquarters staff to ensure compliance with the mandatory provision of CPR by correctional officers.

39. Further, since the CDCR's voluntary moratorium on using remote videocameras to monitor "at risk" inmates in March 2006, CDCR has engaged in one-to-one in-person monitoring of inmates at risk for suicide. (Defs.' Trial Ex. 1311 which is a true and correct copy of *Coleman* Stipulated Order, filed July 5, 2006.)

40. The suicide prevention program of 1990 has now been expanded beyond clinicians and correctional officers to include facilities management staff. This expansion to facilities management arose in response to the *Coleman* Special Master's report recognizing certain features of administrative segregation units as a possible cause in the suicide rates. He noticed, upon reviewing data routinely supplied by CDCR for 2004 suicides that 69.2% of those suicides occurred within administrative segregation units. (Defs.' Trial Ex. 1268 which is a true and correct copy of *Coleman* Special Master's Report on Suicides Completed Within CDCR in Calendar Year 2004, filed December 18, 2006 at 1.) Court monitors found 73% of suicides occurred within single cells, with 43% occurring in single cells in administrative segregation or secure housing units. Some 85% committed suicide by hanging. (Defs.' Trial Ex. 1281 which is a true and correct [15] copy of Patterson & Hughes, *Review of Completed Suicides in the CDCR, 1999 to 2004*, Psychiatric Services (June 2008) Vol. 59, No. 6, p. 678.) Further, of the suicides

within administrative segregation, 53% of such suicides occurred within three weeks of placement. (*Id.*)

41. Correctional and Health Care staff of CDCR examined each of these findings on suicide events in a collaborative effort with the Special Master's team and Plaintiffs to create an appropriate plan to reduce suicides in administrative segregation units. (Defs.' Trial Ex. 1279 which is a true and correct copy of *Coleman* Order, June 9, 2005; Defs.' Trial Ex. 1282 which is a true and correct copy of *Coleman* Order, June 8, 2006.) The plan borne of this collaborative work, and ultimately approved by the Court, relied upon correctional officers, facility management, and clinicians to reduce suicides by several means: (a) replacing the large-mesh ventilation screens used for hanging with small-mesh ventilation screens; (b) creating intake cells with no attachment points for newly-placed inmates in administrative segregation units to stay for the first 72 hours of their stay; (c) screening inmates for suicide risk before placement in administrative segregation units; (d) permitting inmates television and other electronic appliances within administrative segregation yards; (e) requiring 30-minute (at staggered intervals) welfare checks of inmates within administrative segregation units; (f) creating additional small management yards to enable greater outdoor exercise time; and (g) double-celling of inmates within administrative segregation units, where possible. (Defs.' Trial Ex. 1141 which is a true and correct copy of *Coleman* Def. Plan to Reduce Suicides in Ad Seg, filed October 2, 2006, as amended in *Coleman* Def. Response to Objections to Submitted Plan, December 1, 2006; Defs.' Trial Ex. 1268 which is a true and correct copy of *Coleman* Special Master's Report on Plan to Prevent Suicides in Administrative Segregation Units, filed December

18, 2006, pp. 4-10; Defs.' Trial Ex. 1153 which is a true and correct copy of CDCR March 12, 2007 Memo re. Television in Administrative Segregation Units; Defs' Trial Ex. 1157 which is a true and correct copy of Defs.' Supp. Report re. Television Access, filed August 2007; Defs.' Trial Ex. 1182 which is a true and [16] correct copy of Department of Finance Letters to Legislature, dated May 2008.)

42. I defer to the Chief Deputy Secretary of Facilities Construction and Management, Deborah Hysen, and the Undersecretary of Operations, Scott Keman, on the status of some of the above items. I can state, however, that the 30-minute welfare checks of inmates within administrative segregation units have been implemented.

43. Given the nature of suicides, the efficacy of this multi-disciplinary approach to suicide prevention is best evaluated over the course of years. (*See* Defs.' Trial Ex. 1281 which is a true and correct copy of Patterson & Hughes, *Review of Completed Suicides in the CDCR, 1999 to 2004*, Psychiatric Services (June 2008) Vol. 59, No. 6, p. 678.)

44. The Suicide Report discussed above provides Headquarters with the necessary information to audit and evaluate at least the implementation of this multi-disciplinary approach to suicide prevention. Because each Suicide Report discusses causes of the suicide and makes recommendations to prevent such suicides, the Suicide Report assists in the development of any quality improvement plan, which must be submitted within 180 days of any suicide. (*See* Defs.' Trial Ex. 1283 which is a true and correct copy of *Coleman* Order, June 13, 2002; *see also* Defs.' Trial Ex. 1279 which is a true and correct copy of *Coleman* Order, June 9, 2005.) Further, the Suicide Report or

suicide review process can refer any member of the mental health, medical, or custody staff, initially judged to have been responsible for incompetence, malfeasance, negligence to another investigatory and/or disciplinary channel.

45. While some may assert the suicide rates have increased since the entry of judgment in 1995, that assertion is only partly correct. What can be said is that the suicide rate varies. Just as the *Coleman* trial court viewed a ten-year database that showed a decline in suicide rates over the interval of 1980 to 1990, so the *Coleman* Special Master has found a variation in the suicide rates over time. (*See* Defs.' Trial Ex. 1273 which is a true and correct copy of *Coleman* F &Rs at p. 70; Defs.' Trial Ex. 1284 which is a true and correct copy of *Coleman* Special Master's Report on Suicides [17] Completed Within CDCR in Calendar Year 2005, filed November 16, 2007, p. 10.)

46. There are certain demographic features that appear among those who commit suicide, regardless of their incarceration status. Drs. Ray Patterson and Kerry Hughes, psychiatrists who serve as *Coleman* monitors, stated, "The third leading cause of death in U.S. prisons is suicide, exceeded by natural deaths and deaths from AIDS. At least six well-known demographic characteristics of persons who commit suicide are shared by the U.S. general population and the incarcerated subpopulation, including age, gender, ethnicity, drug ad alcohol abuse, history of psychiatric treatment, and prior suicide attempts. For the community, more than 90% of people who die by suicide have a combination of those risk factors, such as male gender and increasing age. For the incarcerated population, these risk factors are similar with the exception of the highest rates of suicide being in

the 31 to 40 age range because of fewer numbers of inmates age 41 and older." (Defs.' Trial Ex. 1281 which is a true and correct copy of Patterson & Hughes, *Review of Completed Suicides in the CDCR, 1999 to 2004*, Psychiatric Services (June 2008) Volume 59, Number 6, p. 677.) I am aware that the CDCR suicide rate over the past few years has been above the national average for correctional institutions. It is too early to determine the impact of CDCR's most recent suicide prevention measures on the occurrence of suicide. I believe suicide to be a very complicated phenomenon that rests on many individual factors, and not solely on the conditions within a correctional setting.

47. In my opinion, CDCR has acted since 1990 and continues to act to present day with deliberation and care to reduce the suicide rate among the inmate population.

VI. *Improvements in Mental Health Care Staffing*

48. A broad array of mental health clinicians staff the mental health services delivery system in order to identify and treat mentally ill inmates. They include psychiatrists, psychologists, psychiatric social workers, nurses, occupational therapists, and recreational therapists. The growth in the mental health clinical staffing, particularly in the core areas of psychiatrists, psychologists, and social workers, from the start of this [18] case in 1994 to today is significant: in July 1994, CDCR had approximately 248 such clinical positions available statewide; in June 2008, CDCR had 2,396 such clinical positions statewide. (*See* Defs.' Ex. 1269 which is a Chart of 1994 Mental Health Care Positions; Defs.' Trial Ex. 1235 which is a chart of CDCR 2008 Mental Health Care Positions.)

49. This growth reflects not only better service to the mentally ill inmates but also better management of the mental health services system. By way of background, in the 1980s and 1990s, CDCR underwent a series of studies and reports on its path to formulating a methodology to determine the number of mental health positions for a constitutionally adequate system. In fiscal year 1991/92, CDC had a total of 277.4 positions authorized for mental health care, with some 208 positions filled. (*Id.* at p. 26.) Yet, one report found 732 staff positions would be necessary to adequately staff mental health care for an inmate population of 119,000 inmates. (*Id.* at p. 37:7-13, *cites therein.*) The fiscal year 1992/93 budget for CDC contained only 376.6 authorized mental health care positions to serve an inmate population of 113,000. (*Id.*)

50. Sometime before 1997, CDCR adopted the Prevalence Mix formula to obtain additional mental health staff as the mental health population within each level of care grew. The population projections, created twice per year, established the number of patients expected for each level of care and were used to support budget requests. This was the beginning of a uniform methodology for providing staff.

51. CDCR often complied with court orders to recruit and retain staff at particular institutions with the use of retention and recruitment bonuses. By 2006, it became apparent that the use of these bonuses resulted in a skewed staffing resources between institutions and between CDCR and DMH. (*See* Defs.' Trial Ex. 1305 which is a true and correct copy of *Coleman* Special Master's Report on DMH Clinicians' Salary, filed 1/30/07.) Further, with the *Coleman* court's approval of the Program Guide, additional

staff was needed to implement the provisions of the Program Guide.

52. Because the staffing methodology up until 2006 relied upon the population, [19] CDCR lacked a staffing methodology to obtain Program Guide-mandated staffing based upon the workload requirements outlined in those mental health care policies.

53. The *Coleman* Special Master responded with a recommendation that Defendants submit a budget package to pursue this immediate need for staffing resources necessary to implement the Program Guide and, more significantly, the budget package include funding for an appropriate staffing tool to objectively evaluate and measure the need for staffing resources.

54. With the benefit of the court order adopting the Special Master's findings and recommendations, CDCR prepared and presented to the special session of the Legislature, held in August 2006, a budget proposal for the allocation of some 530.65 permanent and 21.2 limited term positions, together with an allocation of sufficient funding to execute and complete a workload study. The Legislature supported that request.

55. With the influx of those 530.65 permanent and 21.2 limited term positions, CDCR concentrated its efforts on the recruitment of competent staff.

56. By December 15, 2006, the skewed nature of mental health clinician pay between CDCR institutions was remedied when the *Coleman* court approved an across-the-board pay increase for CDCR clinicians, with a waiver of certain Government Code sections that would otherwise create a barrier to the expedited pay package. (Defs.' Trial Ex. 1285, *Coleman* Order, December 15, 2007.) A similar pay package for DMH clinicians was approved by the Court in June

2007 to avoid any competition for staffing resources between these two partners in inmate mental health care. (Defs.' Trial Ex. 1286 which is a true and correct copy of *Coleman* Order, June 28, 2007.)

57. Even with the increase in pay, the *Coleman* Special Master found, "Staffing shortages among supervisory and line psychiatrists and clinicians remained the single most significant barrier to the effective delivery of mental health services in CDCR institutions." (Defs.' Trial Ex. 1109 which is a true and correct copy of *Coleman* Special Master's 17th Report, Part A, filed June 13, 2007, p. 161.)

[20] 58. In response, CDCR launched a focused recruitment and hiring program in November 2007. (Defs.' Trial Ex. 1287 which is a true and correct copy of *Coleman* Order, August 2, 2007; Defs.' Trial Ex. 1288 which is a true and correct copy of Def. CDCR Recruitment Plan, November 2007.) Streamlined hiring, targeted recruitment of mental health clinicians, and marketing of CDCR salaries and benefits were a few of the tactics employed to address outstanding mental health care vacancies. In addition, CDCR obtained a resolution from the State Personnel Board to compress hiring ranks and so increase the number of candidates for mental health positions. (Defs.' Trial Ex. 1170 which is a true and correct copy of State Personnel Board Resolution, 6/14/07.) Certain employment examinations have been put on-line to further enhance recruitment. (Defs.' Trial Ex. 1189 which is a true and correct copy of the CDCR Memorandum re. Online Exams.)

59. Overall clinical staff vacancies in prisons have been reduced over time from 23.6% in January 2008 to 19.7% in June 2008 as a result of the focused recruitment and hiring program initiated in November

2007. (Defs.' Trial Ex. 1288 which is a true and correct copy of *Coleman* Def. Recruitment Plan, October 2007; Defs.' Trial Ex. 1235 which is a true and correct copy of Chart of Mental Health Care Positions and Vacancies.) This vacancy rate has improved measurably over this brief period of time. The recruitment and hiring program is continuing its focus on filling all of the positions established in recent budgets.

60. The highest vacancy rate in the Mental Health Program had been for psychiatrists, at 50.3% in January 2008. This vacancy rate was reduced to 32% in June 2008. Psychologist vacancies were reduced from 24.8% vacancies in January 2008 to 22.6% in June 2008.

61. CDCR has developed new positions to meet the demand for mental health care services. The "pool" of available clinicians hired by CDCR for its Mental Health Program includes psychologists and licensed clinical social workers who perform some of the core functions for services delivery.

[21] 62. To further address this shortfall in mental health clinicians, CDCR has initiated and sponsored a new Mental Health Therapist civil service classification, the approval for which currently is pending approval by the State Personnel Board. This classification will permit CDCR and other state agencies access to additional properly licensed and credentialed clinicians that have, to date, been unavailable within the civil service to work alongside licensed clinical social workers. Within this therapist classification, Marriage and Family Therapists (MFT) will be able to be hired along with licensed clinical social workers to improve CDCR staffing to provide services appropriate to their scope of licensure for the Mental Health Program. MFTs are licensed by the California

Board of Behavioral Sciences, the same Board that licenses Licensed Clinical Social Workers, who already are employed in the CDCR Mental Health Program. Over 29,000 of these MFT clinicians currently are licensed in California. CDCR has also obtained court approval to employ osteopaths with appropriate credentials to provide mental health care services. (Defs.' Trial Ex. 1057 which is a true and correct copy of *Coleman* Order, April 8, 2008.)

63. These additions to the "pool" of available and competent clinicians will assist CDCR in its efforts to fill its clinical position vacancies on a permanent basis and thereby reduce the overall vacancy rate. CDCR presently relies upon contract staff to fill certain positions, particularly in unattractive or remote geographic locations. As the *Coleman* Special Master has noted, the use of contractors resulted in a lowering of the functional vacancy rate for the core mental health positions of psychiatrists, psychologists, psychiatric social workers, and psych techs to 17% in September 2007 through February 2008. (Defs.' Trial Ex. 1112 which is a true and correct copy of *Coleman* Special Master's 20th Report, Part, A, p. 356.)

64. The quality of mental health clinicians has not been sacrificed over the quantity of clinicians. For example, CDCR clarified its standards for employment as a CDCR psychiatrist. CDCR initiated and completed a program to evaluate the competency of those psychiatrists that were neither board certified, nor board eligible. [22] (Defs.' Trial Ex. 1289 which is a true and correct copy of the *Coleman* Stipulated Order, September 11, 2006.)

65. While meeting the immediate need for mental health clinicians, CDCR has worked closely with the Special Master's staff in finalizing the mental health

workload study and so meeting the long-term need for an approved staffing methodology. (Defs.' Trial Ex. 1174 which is a true and correct copy of the *Coleman* Special Master's Report, dated July 12, 2008; Defs.' Trial Ex. 1168 which is a true and correct copy of the CDCR Workload Study.) The mental health workload study, approved on September 23, 2008 as part of the State Budget, establishes accurate a formula for determining, at each prison site, the staffing levels needed for the delivery of mental health care services necessary to comport with the Program Guide.

66. The staffing of Headquarters management has not gone overlooked. A *Coleman* court order enabled CDCR's use of salary differentials to develop a headquarters management and staffing structure that recognizes and accounts for the management of mental health services as a major program of the CDCR. (Defs.' Trial Ex. 1291 which is a true and correct copy of the *Coleman* Order, filed March 7, 2005.) By February 2007, the "allocations of headquarters staffing quintupled the number of positions available at the Division of Correctional Health Care Services to enhance, among other policy and monitoring capabilities, the ability to compile, collate and analyze data on CDCR's mental health system." (Defs.' Trial Ex. 1109 which is a true and correct copy of the *Coleman* Special Master's 17th Report, Part A, filed February 9, 2007, p. 103.) That additional headquarters staffing has made possible centralized oversight, direction, and responsibility for a mental health care services delivered at each of the 33 CDCR institutions. Attached is a set of charts illustrating the organization of CDCR Health Care Services Division. (Defs.' Trial Ex. 1220 which is a true and correct copy of the CDCR Health Care Regional Administration Chart;

Defs.' Trial Ex. 1260 which is a true and correct copy of CDCR Executive Management Chart.)

67. With the use of prison-based staffing methodology for essential services [23] and core headquarters responsibility for management and staffing of the Mental Health Program, the mental health services delivery system is now at a point at which its succession as well as success can be sustained.

68. Staffing in both the prisons and Mental Health headquarters has reached a level such that the services required of each now can be provided with reduced reliance on overtime or contracted positions. Establishing this staff capability is a major accomplishment and coupled with the knowledge of the approved program represented in the Guide, moves this Mental Health Program further toward its compliance goals.

69. I expect that this combination recruitment efforts, streamlined hiring, and an expanded pool of appropriate clinicians that are available for hiring into CDCR soon will eliminate the clinical vacancies in our prison Mental Health Program. These staffing actions reflect the kind of management attention to the issues of staffing the mental health services delivery system that shows deliberate interest in the care of the mentally ill inmate and in complying with the Program Guide standards, notwithstanding population growth.

VII. *Mental Health Care Beds*

70. In 1995, the identified population of inmates requiring mental health care was 7.9%. The designated beds for mental health inmates were insufficient, as follows:

> a. Inpatient hospital care was provided predominantly at California Medical Facility and Atascadero State Hospital by the Department of Mental Health (708 beds), with 18 inpatient beds at the California Institution for Men staffed by CDCR personnel.
>
> b. Enhanced Outpatient Program Beds were provided at three institutions (California Medical Facility, California Men's Colony and California Institution for Women) in the amount of 2,421 beds.
>
> c. Crisis beds: provided on an "informal" basis within each institution, depending upon available resources. Some 30 to 40% of the infirmary beds were used for mental health crisis care.
>
> [24] d. Outpatient care: provided on an "informal" basis and primarily limited to medication only, with psychological services dependant upon the availability of staff.

(Defs.' Trial Ex. 1273 which is a true and correct copy of the *Coleman* F&Rs, filed June 6, 1994, pp. 43-44.)

71. CDCR endeavored to create a decentralized system of mental health care to enable access to mental health services at every institution. The mental health population, hovering now at 20% of the overall CDCR population, requires housing and treatment space for some 28,000 patients at the Correctional Clinical Case Management System housed with general population inmates and for the remaining patients—those within Enhanced Outpatient Program, Mental Health Crisis Beds, inpatient intermediate and inpatient acute care—housed separately from the general population. Inpatient intermediate and inpatient acute care has expanded beyond Atascadero

State Hospital and California Medical Facility to now include other Department of Mental Health hospitals, such as Coalinga and Patton State Hospitals, and to include DMH facilities located on CDCR sites (Vacaville Psychiatric Program and Salinas Valley Psychiatric Program).

72. The endeavor to create sufficient space for the mental health services delivery system was, to some extent, stymied by the physical design of the prisons and state hospitals themselves. The *Plata* Receiver "traces Defendants' lack of adequate clinical space to the design decisions made in the 1980s." (Defs.' Trial Ex. 1292 which is a true and correct copy of the *Coleman* Special Master's May 31, 2007 Response to Court's May 17, 2007 Request for Information, p. 5.) These prisons were designed and built to accommodate population growth, with "infrastructure, including just water, wastewater, electrical and mechanical components, needed to meet anticipated overcrowding of as much as 190 percent in cells and 140 percent in dormitories." (*Id.*) In contrast, these same prisons were not designed and made "no provision" for any expansion of medical care space beyond the initial 100% of capacity. (*Id.* at pp. 4, 5.) [25] Even worse, "none of the 19 CDCR institutions planned and built in the boom of the 80s and 90s gave any thought to the space that might be needed for mental health purposes." (*Id.* at p. 5.) A similar failure in design vision occurred with the Department of Mental Health, which discovered in 1998 that it had "no facilities of its own in which to provide the level of inpatient care needed by CDCR for high custody inmates with a history of violence or escape." (*Id.* at p. 8.) As a result, such patients often wait for an appropriate inpatient bed staffed by the DMH within a DMH facility

located at a CDCR site, such as Vacaville Psychiatric Program or Salinas Valley Psychiatric Program.

73. CDCR and DMH have engaged in ongoing efforts to create additional mental health care space and housing in CDCR facilities. For instance, in 2004, the Salinas Valley Psychiatric Program, within Salinas Valley State Prison, activated and filled 64 intermediate care beds. (Defs.' Trial Ex. 1293 which is a true and correct copy of the *Coleman* Special Master's 14th Report, filed February 11, 2005, p. 176) Two years later, DMH added 112 intermediate inpatient care beds, particularly designed for high custody (Level IV) inmates, to Salinas Valley Psychiatric Program. (Defs.' Trial Ex. 1109 which is a true and correct copy of the *Coleman* Special Master's 17th Report, Part A, filed February 9, 2007, p. 114.) At the same time, CDCR created an additional 11 mental health crisis beds as well as a new 64-bed Psychiatric Services Unit at California State Prison, Sacramento. (Defs.' Trial Ex. 1294 which is a true and correct copy of the *Coleman* Special Master's 16th Report, filed December 14, 2006, p. 5.) Kern Valley State Prison opened in 2005 and then opened its mental health crisis bed unit in 2006. (Defs.' Trial Ex. 1109, *Coleman* Special Master's 17th Report, Part C, filed June 11, 2007, pp. 2-3.) By 2007, the California Medical Facility had converted two units, P-2 and P-3, to intermediate care beds for Level III and Level IV inmates, with a total capacity of 66 intermediate care beds. (Defs.' Trial Ex. 1111 which is a true and correct copy of the *Coleman* Special Master's 19th Round Report, filed July 25, 2008, p. 20.)

74. The impact of increased mental health beds is easily seen. In January 2008, California State Prison-Sacramento activated an additional sixty-four

Psychiatric [26] Services Unit beds, increasing statewide capacity of Psychiatric Services Unit beds to 384 and resulting in a decrease in the waitlist for such beds decreased from 79 on January 1, 2008 to 22 on July 18, 2008. (Deft.' Trial Ex. 1185 which is a true and correct copy of the California State Prison, Sacramento, Psychiatric Services Unit Activation Memorandum, January 2008.) In June 2008, the California Medical Facility opened a fifty-bed mental health crisis bed unit. While the October 1, 2007 census for such mental health crisis beds was 215 with a wait list of 33, by July 21, 2008, the mental health crisis bed census was 301 and the wait list was at 16. Kern Valley State Prison recently opened 96 sensitive needs yard-Enhanced Outpatient Program beds, allowing for the transfer of many Enhanced Outpatient Program patients who were placed in an administrative segregation unit for safety reasons to be moved to a sensitive need yard bed. (Defs.' Trial Ex. 1186 which is a true and correct copy of the Kern Valley State Prison Activation Memorandum, August 2008.)

75. In sheer numbers, the mental health delivery system has increased dramatically over the years. As the attached chart shows, CDCR now provides at institutions across the State: 25,072 beds for those inmates requiring correctional clinical case management system level of care; 3,763 Enhanced Outpatient Program beds; 336 mental health crisis beds; 26 mental health outpatient beds; and 384 psychiatric services unit beds. (Defs.' Trial Ex. 1247 which is a true and correct chart of CDCR Facilities.) In addition, there are 801 acute and intermediate care beds provided and/or staffed by the Department of Mental Health. (*Id.*) Notably, some of these units, such as Psychiatric Services Units to house those mentally ill

inmates requiring enhanced outpatient care and posing administrative segregation unit issues, did not exist in 1997.

76. Because the policy and procedure has been to provide segregated housing to mentally ill patients receiving Enhanced Outpatient Patient care or higher levels of (inpatient) care, that means that such mentally ill patients of CDCR are not housed within triple-bunked gymnasiums or dayrooms. They are thus insulated from the impact, if any, of the overall crowding of CDCR housing facilities.

[27] 77. Likewise, those mentally ill inmates requiring inpatient care within a mental health crisis bed, an acute bed or an intermediate care bed are in mental health units separated from the general population of inmates and, due to licensure requirements, immune from the triple-bunking seen in gymnasiums and dayrooms.

78. While mentally ill inmates at the lowest level of outpatient care, Correctional Clinical Case Management Services, are permitted to be housed in general population areas, the data shows that the majority, some 80 percent, of these patients are in traditional housing and not in "non-traditional settings" of dayrooms and gymnasiums. (Defs.' Trial Ex. 1252 which is a true and correct copy of a CDCR Chart of Non-Traditional Beds.)

79. Even at CDCR reception centers, inmates awaiting screening and transport to appropriate mental health beds are given care. By way of background, reception centers screen (incoming) inmates for mental health care needs. Those inmates found to need Enhanced Outpatient Program care are endorsed for transfer and placement in an institution with that

level of care. Should an Enhanced Outpatient Program bed not be immediately available, then those mentally ill patients requiring Enhanced Outpatient Program care are given enhanced outpatient care while in reception centers awaiting transfer. (Defs.' Trial Ex. 1142 which is a true and correct copy of the CDCR Plan to Provide EOP Care in Reception, dated October 2007, with supplement December 2007; Defs.' Trial Ex. 1179 which is a true and correct copy of CDCR Plan to Provide EOP Care in Reception, dated May 1, 2008.) This provision of EOP care in reception centers is an interim means for meeting the needs of mentally ill inmates while a permanent solution, the construction of additional EOP beds, is underway.

80. CDCR Mental Health recognizes that the long-term forecast for an increase in the mental health population must be met. CDCR has plans to create more treatment and housing space for *Coleman* class members, particularly those inmates requiring high-custody inpatient beds. Indeed, the Special Master has found the high custody inpatient beds to be of critical importance, remaining critical regardless of the overall [28] population of CDCR or even a release of CDCR inmates. (Defs.' Ex. 1192 which is a true and correct copy of the *Coleman* Special Master's May 31, 2007 Response to Court's May 17, 2007 Request for Information.)

81. CDCR, in collaboration with DMH, has created a series of plans to address the need for acute and intermediate inpatient beds and the need for mental health crisis beds, as described in *Coleman* court orders. (Defs.' Trial Ex. 1042 which is a true and correct copy of the *Coleman* Order of March 3, 2006, Defs.' Trial Ex. 1296 which is a true and correct copy of the *Coleman* Order of May 2, 2006.) Because

Defendants were ordered to coordinate their compliance efforts, particularly those involving bed planning and construction, with the Receiver, the bed plans have been developed with the Receiver's input. (Defs.' Trial Ex. 1297 which is a true and correct copy of the *Coleman* Order, October 20, 2006.)

82. In August 2007, Defendants submitted a long-term plan for the provision of mental health care beds. That plan was premised upon the construction of 'consolidated care centers', housing both medical and mental health (inpatient and Enhanced Outpatient Program) beds in conjunction with the Receiver. (Defs.' Trial Ex. 1139 which is a true and correct copy of the August 2007 Bed Plan; Defs.' Trial Ex. 1298 which is a true and correct copy of the Special Master's Report on the August 2007 Bed Plan, filed September 2007.)

83. In contrast to previously-submitted bed plans, the hallmark of the August 2007 bed plan was its utilization of a validated mental health bed forecast methodology by an outside vendor, Navigant Consulting. The bed-demand forecast and its resultant bed plan also is an essential aspect of management that was re-initiated in 2006.

84. The August 2007 long-term bed plan presented a comprehensive program for developing and constructing the space and beds needed to provide adequate mental health services for the growing population over the next 5 years. The plan results in over 7,400 residential mental health beds (Enhanced Outpatient Program, mental health crisis bed, acute inpatient and intermediate inpatient care.) Under the August 2007 [29] mental health bed plan, CDCR anticipated building in the consolidated care centers the following: 2,532 general population Enhanced Outpatient Program beds and 709 high-custody

Enhanced Outpatient Program beds for men, plus 168 general population Enhanced Outpatient Program and 15 Enhanced Outpatient Program high-custody beds for women, for a total of 3,424 Enhanced Outpatient Program beds. The plan included an additional 150 Enhanced Outpatient Program beds at California State Prison, Los Angeles County. Further, acute and intermediate care beds will be constructed to meet the forecasted needs of mental health care patients.

85. The August 2007 bed plan was approved by the *Coleman* court, with the caveat that CDCR and DMH submit an additional plan concerning the staffing and accreditation of the inpatient care beds. (Defs.' Trial Ex. 1038 which is a true and correct copy of the *Coleman* Court order of October 2007.)

86. The July 2008 mental health bed plan presented the Department of Mental Health as the agency responsible for staffing the new inpatient mental health beds and thus providing its expertise in creating a therapeutic environment for these mentally ill inmates. (Defs.' Trial Ex. 1175 which is a true and correct copy of the July 2008 Mental Health Bed Plan.) In preparing the July 2008 mental health bed plan, CDCR noticed changes in the population projections for the Enhanced Outpatient Program level of care. (*See* Defs.' Trial Ex. 1162 which is a true and correct copy of the Navigant/Misener Forecast Report, June 2008.) Thus, the July 2008 bed plan proposed a different configuration of Enhanced Outpatient Program beds in the consolidated care centers (also known as consolidated health care facilities): 2,245 general population Enhanced Outpatient Program beds and 598 high custody Enhanced Outpatient Program beds for men, plus 255 general population Enhanced Outpatient Program beds and

27 high-custody Enhanced Outpatient Program beds for women, for a total of 3,125 new beds. CDCR also anticipates adding an additional 67 general population Enhanced Outpatient Program beds at California Medical Facility. That raises the total new Enhanced Outpatient Program beds in the proposed plan to 3,192.

[30] 87. The construction of the beds depicted in the July 2008 bed plan presently are subject to coordination with the construction of medical beds by the Receiver in *Plata*. I understand a modification of the CDCR Long-term Mental Health Bed Plan may require re-submittal for *Coleman* court approval by the end of 2008 depending on the results of this coordination. Whether these beds are to be included within the Receiver's construction program or they are to proceed as CDCR separate projects, the commitment to their completion remains.

88. CDCR has persevered in the development of mental health care space at existing facilities and now in new facilities with the Department of Mental Health, and possibly shared with the Receiver's medical care system.

89. Clearly, the construction of mental health care space is a core element of an adequate mental health services delivery system. Yet this element, like the other elements, is management-driven. When well served by management, these elements together form the basis for compliance notwithstanding population growth.

VIII. *Record Keeping, Pharmacy, and Information Technology*

90. As the head of CDCR Health Care, I am aware that compliance in both the *Plata* and *Coleman*

actions has been impeded by the lack of adequate record keeping, pharmacy, and medication management systems. Indeed, the medical, mental health, and medication records of patients have been consistently maintained in hard copy fashion, requiring dedicated staff to maintain the files and make those files available to clinicians working with patients. CDCR has explored various means of bringing electronic recordkeeping to its institutions. The actual installation of electronic technology is often stymied by the aged conditions of buildings, including the challenge of wiring walls containing asbestos and lacking appropriate electrical infrastructure.

91. Under the Coordinated Courts' recent order, the development of an automated electronic information system is to be undertaken by the *Plata* Receiver. (Defs.' Trial Ex. 1299, Coordinated Courts' Order, filed June 28, 2007.) I understand from the *Plata* Receiver that this new information system should become operational [31] over the next 18-24 months. The system will provide comprehensive data to inform all aspects of mental health care and management. The provision of this data readily and on a regular basis will enable the timely and appropriate delivery of medications and mental health care programming to patients. Such information technology will support day-to-day management, quality management committees, program evaluation, performance assessments, and overall patient care.

92. The Coordinated Courts also vested the Receiver with responsibility for the pharmacy. (Defs.' Trial Ex. 1299, Coordinated Court's Order, filed June 28, 2007.) A majority of *Coleman* class members are reliant on timely and appropriate medication for their mental illnesses. CDCR Mental Health anticipates the

Receiver's efforts to improve pharmacy will serve to improve the medication management of Coleman class members.

93. The CDCR anticipates this cooperative relationship with the Receiver on information technology and pharmacy issues will enable a finding of compliance on those elements of an adequate mental health care system.

IX. *Quality Management Systems*

94. The *Coleman* trial court noticed the complete lack of any peer review or other quality management system within ODOR Mental Health Care. (Defs.' Trial Ex. 1273, Coleman F&Rs, filed June 6, 1994.)

95. CDCR now employs a Quality Management system for Mental Health both in its prisons and in Mental Health Headquarters. This system is a variant of such systems that are prevalent within the health care industry. Its fundamental elements are comprised of a committee structure with membership made up of all stakeholders within the respective prisons, regular documented meetings, routine identification of problems in the delivery of services, attention to the corrective actions identified by court monitors, and a structured process of multi-disciplined quality improvement teams operating under the committee's direction to resolve problems and recommend corrective actions. Corrective actions may involve the custody or administrative functions as well as the direct provision of mental health services.

[32] 96. Similarly, Mental Health Headquarters operates a Quality Management Committee system that includes centrally-directed actions, such as facility construction, policy determination, staff recruitment and others, as well as addressing systemic issues that

inhibit prison staffs ability to reach appropriate levels of compliance with governing policy and procedure. Together with the prison-based committees, this Headquarters committee provides a broad process of problem resolution that operates alongside day-to-day management activities.

97. In 2003 CDCR successfully experimented with the Program Support and Quality Management efforts; CDCR has revived those efforts now. A primary element of Headquarters operations is the Program Support Team aspect of the Compliance Unit. Individual teams of clinical and administrative staff are assigned to particular prisons to assist in the development of the quality improvement processes, as well for the resolution of specific ongoing problems that require correction. These Headquarters-based teams become a tool for connecting prisons struggling to achieve regular compliance with the expertise provided through the "team" and support that is designed to improve overall performance.

98. This aspect of the Headquarters organization is now operational and provides effective focus on performance outcomes. Over time this effort will provide an adjunct to the staffing and facility development aspects of this system that will tend toward establishing the teamwork that is needed to achieve compliance.

99. Another element of management that has not been present in CDCR is Program Evaluation, an organizational element of headquarters that conducts regular, annual reviews of the Mental Health Program in each prison. It serves to monitor general and selected elements of program requirements and produces a score for each prison with respect to compliance in each element. Program Evaluation is

just now under development and is expected to begin its initial evaluations in early 2009.

100. Also in development is the Mental Health Utilization Management (UM) function. This function is intended to provide assurance that mental health patients are [33] placed in the level of care required by their condition and are appropriately transferred through proper levels of care in a timely manner. This UM function focuses on the specific patients in the mental health caseload and provides assurances that they are being treated in accordance with the Program Guides and their level of mental health acuity.

101. It is notable that the former Special Master Keating noted in his May 31, 2007 report that CDCR had come close in 2003 to achieving a degree of success that had not been achieved up to that time. He also stated that the reduction of population in CDCR would not have an appreciable impact on the care provided to the *Coleman* caseload. (Defs.' Trial Ex. 1292, *Coleman* Special Masters Report, filed May 31, 2007.)

X. *Summary*

102. The Mental Health organization in headquarters has been completely revamped to incorporate all of the above-described management functions that can assure continued improvement in the provision of necessary services. This restructured organization establishes the ability of CDCR to continue to make gains on compliance with the requirements of the Mental Health Program.

103. Now organized to provide specific staff attention to court compliance, this new organization also produced 5 plans for additional services required by

the *Coleman* court that are now pending with the Court for approval: (1) plan to utilize fully the Intermediate Care beds at Atascadero State Hospital; (2) plan to improve Enhanced Outpatient Care in administrative segregation; (3) plan to further improve mental health assessments for caseload inmates subject to the disciplinary process; (4) plan to improve Enhanced Outpatient Services in reception centers; and (5) a plan to improve staff recruitment and hiring. (*See* Defs.' Trial Exs. 1177-1181 which are true and correct copies of Defs.' Five Plans, May 1, 2008.) These plans are being implemented as feasible by CDCR even pending court approval, although modifications based on testing may be required.

104. As a government manager with extensive experience, I am confident that [34] the management elements described above, if continued with due diligence and support will achieve full compliance with the Program Guides whether or not population growth continues.

I declare under penalty of perjury that the foregoing is true and correct. Executed in Sacramento, California on October 30, 2008.

/s/ ROBIN DEZEMBER
ROBIN DEZEMBER

[1] UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. 2:90-cv-00520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

JOINT PRE-TRIAL STATEMENT

To: Three-Judge Panel

* * *

[37] 5. Sonoma County Intervenors

Sonoma County Intervenors concur with Defendants' identification of relevant points of law.

D. CCPOA

Plaintiff intervenor CCPOA joins in plaintiffs' identification of relevant points of law.

V. LIST OF WITNESSES

A. Defendants

Christopher Mumola (via deposition, witness is unavailable)

Cynthia Radavsky

David L. Thomas

Deborah Hysen

Gale Bataille

Ira Packer, PhD, ABPP

James Tilton

James W. Marquart, Ph.D.

Kathryn P. Jett

Mathew Cate

Ralph Coleman (via deposition, pursuant to parties' stipulation)

Ray Stoderd (via deposition, pursuant to parties' stipulation)

Robin Dezember

Scott Kernan

Thomas L. Hoffman Todd Jerue

B. Plaintiffs

(a) Deposition testimony

See Exhibit C for Plaintiffs' Deposition Designations.

(b) Live testimony (each of the following is an expert witness) Craig Haney, Ph.D., J.D.

EXHIBIT 1

Deposition of David Bennett, September 9, 2008 (Designations)

* * * *

[5] BE IT REMEMBERED that on Tuesday, the 9th day of September, 2008, commencing at the hour of 3:02 p.m. at the offices of K&L Gates, 55 Second Street, Suite 1700, San Francisco, California, before me, THOMAS J. LANGE, a Certified Shorthand Reporter in and for the State of California, personally appeared

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DAVID BENNETT

called as a witness herein, who, having been duly sworn, was thereupon examined and interrogated as hereinafter set forth.,

EXAMINATION BY MR. BORNSTEIN

Q. Will you please state and spell your name for the record?

A. David Bennett, B-e-n-n-e-t-t.

Q. Mr. Bennett, my name is Jeff Bornstein. I represent the plaintiffs in this prison overcrowding case. I'll be asking you a series of questions today. You are under oath and the testimony that you're giving is obviously subject to penalty of perjury.

Do you understand that?

A. I do.

Q. And, of course, the court reporter is here and will be taking down everything that's said. Very important that you answer audibly.

* * * *

[75] MS. FRITZ: Calls for a legal conclusion.

MS. KECK: As determined by—I'll object as same. As determined by a court or his own opinion?

Q. BY MR. BORNSTEIN: Do you understand my question?

A. I have worked in numerous jurisdictions that have operated overcrowded jails as determined either by a court or a local determination.

Q. Well, let's take—let me refine the question.

In this case, the court has already determined that the California prison system is in violation of the Constitution because of its failure to provide adequate medical and mental healthcare to inmates. Are you aware of that?

A. Yes.

Q. Do you believe that that is a function of overcrowding?

MS. KECK: I'm going to object that this calls not only for a legal conclusion, but something that is outside the scope of this witness's testimony and his expected testimony. He's not been engaged to-render an expert opinion in this regard.

Q. BY MR. BORNSTEIN: Go ahead.

A. In part.

Q. What do you mean?

[76] A. As has been documented in the expert reports, with the level of overcrowding in the, prison just logistically, it has proven to be very difficult, if not impossible, to provide that level of care that is

required. But it's not just the fact that there isn't the physical space to do that, that it is—and/or that the number of prisoners prohibits that, but it's also having in place the structure, the structure to systematically provide the risk and needs assessment of the offenders, the structure in place to provide that subsequent identification and referral to treatment, that ability to provide services both within the facility and, just as importantly, out in the community.

Q. Would you agree that when a prison is—has a rated capacity, I don't know, 80,000 beds, and yet it is housing 176,000 inmates or 156,000 inmates—I don't know the number right now—that that increases the —or exacerbates, I should say, the problem of providing adequate medical and mental healthcare?

MS. KECK: Same objection. Outside the scope.

THE WITNESS: Yes.

Q. BY MR. BORNSTEIN: And would you agree that reducing the number of prisoners is at least one of the first steps that needs to be taken while you're doing—while you're kind of working on the infrastructure of

* * *

EXHIBIT 19

Deposition of James Tilton
September 3, 2008
(Designations)

Part A

[1] UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA AND THE
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No CIV S-90-0520 LKK JFM P

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

MARCIANO PLATA, *et al*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

Deposition of JAMES EDWIN TILTON

DATE:	SEPTEMBER 3, 2008
TIME:	9:41 A.M.
LOCATION:	ROSEN, BIEN & GALVAN 315 Montgomery Street, 10th Floor San Francisco, California 94104

* * * *

[15] Q. Let's shift to your employment history. I know that you retired as secretary of the CDCR. On what date did you first become an acting secretary?

A. April 18th of '06.

Q. And what was your position immediately before that?

A. Before that, it was called—what's called a program budget manager with the Department of Finance.

Q. And in your role of Department of Finance, did you have responsibility for CDCR budget matters?

A. Yes, I did.

Q. Okay. And how long did you have that position at DOF?

A. That position, approximately three years.

Q. Okay. And you were at DOF before that?

A. Yes.

Q. How long have you been at DOF?

A. Since 1998.

Q. Okay. In various positions at the Department of Finance?

A. Right, two positions. Right.

Q. And at what point in your work at Department of Finance did you first have any responsibility for CDC's, Department of Corrections, budget items?

A. Well, the last three years, I was responsible [16] for their support budget. The prior five years, I was responsible for their capital outlay. Their construction program was under my purview.

Q. And prior to 1998, where did you work?

A. Prior to 1998, I was the deputy director for administration for the Department of Corrections.

Q. And how long did you have that position?

A. That particular position; I think, since 1987.

Q. In general, what were your responsibilities in that time period?

A. I was responsible for all the administrative functions, which is procurement, accounting, budgeting, personnel. At one period, I had all of the IT programs. I had health and safety, labor relations for a while, and training.

Q. And training?

A. And training, right.

Q. Who did you report to as deputy director?

A. I reported to the chief deputy director.

Q. And did the chief deputy director report to the secretary during that period?

A. No, he reported to the director of corrections.

Q. Director of corrections, that's right.

And during that period, there was a State [17] entity called Youth and Adult Correctional Authority; is that correct?

A. The Youth and Adult Correctional Agency?

Q. Correctional Agency, yes.

A. Yes.

Q. And that was the secretary level, at that point?

A. That's correct.

Q. Prior to becoming deputy director for administration, did you have other positions at CDCR?

A. Yes, for the two years prior to that, I was assistant deputy over financial operations.

Q. Did you ever work for CDCR in a purely custodial position, such as warden or deputy warden?

A. No.

Q, Were you ever a correctional officer?

A, No.

Q, When did you first begin working at CDCR?

A. In 1985.

Q. What was your prior work experience before that?

A. I was with the Department of Finance. Classification was principal program budget analyst, and I had the corrections assignment.

Q. Okay. And when did you begin that period of

* * * *

EXHIBIT 19

Deposition of James Tilton
September 3, 2008
(Designations)

Part B

* * *

[79] So we—the fact that we had overcrowding and the lack of opportunities for program made it worse.

Q. So if you're living in a gym, but you have—you're on the main line and working and going to classes all day long, it might be less of a problem than if you are living in a gym and you have no programming?

MS. TILLMAN: Objection. Vague and ambiguous. Incomplete hypothetical.

Go ahead.

THE WITNESS: Yes, that's my point.

MR. BIEN: Q. Is it correct that, at times, CDCR has used these gyms and day rooms for housing but had greater access to programs for the inmates living in those housing?

A. Yes

Q. So that the situation, as you just explained, it's not merely the lack of just the use of gyms, butalso the fact that a situation happened where there were also not opportunities for programming at the same time people were being housed in the gyms?

A. True.

Q. Farther down that same paragraph, it states, "In addition, the overcrowding and lack of treatment space to service the additional populations has been a major 'contributor to court intervention regarding CDCR's [80] healthcare services delivery. The CDCR is currently operating under stipulated court agreements for medical, mental health, and dental services, and is under receivership for medical services."

Can you explain how the overcrowding and lack of treatment space had contributed to difficulties in CDCR complying with the mandates of these cases?

MS. TILLMAN: I'll object. It misstates the evidence in the document.

If you can answer, go ahead.

THE WITNESS: Well, I think what we were raising here is the issue that the lack of space is not only a housing issue, but it's impacting the other factors, like delivery healthcare service, the lack of offices, and clinical space.

MR. MEN: Q. Did you believe, in the summer of 2006, that that was a contributing factor to CDCR's difficulty in complying with, for example, the *Coleman* Court inmates for treatment?

MS. TILLMAN: Misstates the evidence. Assumes facts not in evidence.

You can answer.

THE WITNESS: It was clear to me that the lack of program space was not just education, vocational. It also is the ability to provide the mental health and . . .

* * *

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TENTATIVE RULING

Having heard the evidence and arguments presented by the parties and intervenors, we will now make a tentative ruling. Although it will take the Court some time to review all the evidence that has been presented and to issue a final opinion, we have decided to make this tentative ruling in order to give the parties notice of the likely nature of that opinion, and to allow them to plan accordingly.[1] (The term parties as used throughout shall, where appropriate, include the intervenors.)

[2] We tentatively conclude the following:

1. First, plaintiffs have presented overwhelming evidence that crowding is the primary cause of the underlying constitutional violations. No party contests that California's prisons are overcrowded, however measured, and whether considered in comparison to prisons in other states or jails within this state. There are simply too many prisoners for the existing capacity. The Governor, the principal defendant, declared a state of emergency in 2006 because of the "severe overcrowding" in California's prisons, which has caused "substantial risk to the health and safety of the men and women who work inside these prisons and the inmates housed in them." Pls.' Exh. P-1. A state appellate court upheld the Governor's proclamation, holding that the evidence supported the existence of conditions of "extreme peril to the safety of persons and property." *CCPOA v. Schwarzenegger*, 163 Cal. App. 4th 802, 818 (Cal. App. Ct. 2008). The Governor's declaration of the state of emergency remains in effect to this day. Moreover, in the underlying cases, the court found that the States have failed to deliver constitutionally adequate mental or physical healthcare. Those determinations have not been questioned in the courts that made those findings, nor has there been an appeal of those orders.

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[1] Although we refer to the evidence in the record in this tentative ruling, we continue to reserve final rulings on all of the outstanding evidentiary objections.

Under these circumstances, the disagreement between the parties cannot be whether overcrowding in California's prisons exists or whether that condition constitutes extreme peril to health and safety. Rather it is whether overcrowding is the "primary cause" of the State's inability to provide constitutionally adequate medical care and mental health care to its prisoners. We agree with the defendants that "primary cause" means the "chief, principal, or root" cause. We also agree that the delivery of constitutional medical and mental health care in prisons is a complicated and "polycentric" problem. As we have stated before, however, we believe that a polycentric problem can have a primary cause – a cause that underlies and affects nearly every dimension of the problem and that in this case must be substantially mitigated before the constitutional failure can be resolved.

Evidence offered at trial was overwhelmingly to the effect that overcrowding is the primary cause of the unconstitutional conditions that have been found to exist in the [3] California prisons. There is, for example, uncontroverted evidence that, because of overcrowding, there are not enough clinical facilities or resources to accommodate inmates with medical or mental health needs at the level of care they require. There is also uncontroverted evidence that, because of overcrowding, there are not enough clinical or custodial personnel to ensure that inmates with medical or mental health needs are receiving appropriate treatment, are taking the medications that they need to take, are being escorted to their medical appointments in a timely manner, and are having their medical information recorded and filed properly. Additionally, as the Governor has stated, and as the California appellate court has found, overcrowded conditions – the use of triple bunks in gymnasiums and other areas not intended to be used for housing, for example – have "substantially increased the risk of the transmission of infectious illnesses among inmates and prison staff." *CCPOA*, 163 Cal. App. 4th at 819-20.

Almost every expert who testified in the first phase of the trial identified overcrowding as the main cause of the prison system's constitutionally inadequate medical and mental health care and as the problem that must be fixed before constitutionally adequate care can be delivered. Among the experts was Ms. Jeanne Woodford, the former acting Secretary of the California Department of Corrections and Rehabilitation, who testified that it is impossible to get inmates necessary mental health treatment and health care exams when operating in the overcrowded setting of California's prisons. Experts with correctional experience in states ranging from Texas and Pennsylvania to Maine and Washington testified to similar effect. Even defendants' expert, Dr. Ira Packer, agreed that the primary cause of the inadequacy in mental health care is that there are not enough mental health resources for the population. He also concluded in his expert report that crowding is the primary cause of the problems at the reception centers.

The defendants argue that the work of the Receiver and the Special Master has significantly improved the conditions in the prisons, and that with more time the Receiver and California Department of Corrections and Rehabilitation (sometimes referred to as CDCR), as monitored by the Special Master, can remedy the constitutional violations [4] without decreasing the prison population. Although we agree that the Receiver and the Special Master have succeeded in improving some of the conditions in the prisons, no party has argued before the *Plata* or the *Coleman* courts that the unconstitutional conditions have abated. The Special Master stated that although much has been achieved in the past eleven years, "many of these achievements have succumbed to the inexorably rising tide of population." Pls.' Exh. P-35. The Receiver stated in a letter to the Governor and legislators dated July 24, 2006, that "[i]t will not be possible to raise access to, and quality of, medical care to constitutional levels with overpopulation at its current levels." Pls.' Exh. P-55. In addition, of course, the Receiver's ability to help ameliorate the overcrowding is currently seriously threatened by the defendants' actions to cut off his funding and terminate the receivership.

2. Second, the evidence is compelling that there is no relief other than a prisoner release order that will remedy the unconstitutional prison conditions. As defined in the PLRA, other "relief" refers only to relief other than a prisoner release order "that may be granted or approved by the court." 18 U.S.C. § 3626(g)(9). We would be remiss, however, if we did not take note at the outset of this section that California, like most other states, is in the throes of an unprecedented economic crisis and that the budgetary implications are of the most serious order. There are simply no additional funds that are currently being made available by the State to deal with the critical problem created by prison overcrowding.

The two cases underlying this three judge proceedings have been in the federal courts for a very long time: *Coleman* has been in its remedial stage since 1995, and *Plata*, since 2002. The respective district courts have entered a number of orders short of a prisoner release order aimed at remedying the constitutional violations. In *Coleman*, the court has entered at least 77 substantive orders to defendants since 1996, including the order appointing the Special Master. Order, *Coleman v. Schwarzenegger*, 2007 WL 2122636, *2 (E.D. Cal. July 23, 2007). In *Plata*, the defendants' failure to bring the prison system into constitutional compliance, despite reasonable opportunity to do so, compelled the court to appoint a Receiver. *See* Findings of Fact and Conclusions of Law Re Appointment of [5] Receiver, *Plata v. Schwarzenegger*, 2005 WL 2932253, *27 (N.D. Cal. Oct. 3, 2005). In granting the motion to convene this panel, both courts concluded that these orders for "less intrusive relief" had failed to remedy the unconstitutional conditions.

The defendants argue that the Receivership and the Special Master's monitoring efforts constitute other "relief" short of a prisoner release order that could remedy the constitutional violations. But the defendants have opposed the Receiver's work in *Plata* and are seeking the dissolution of the Receivership. They have also been unable to bring their mental health care delivery system into constitutional compliance at any point in the past fourteen years. Moreover, as stated in the defendants' motion before the *Plata* court, "California faces an unprecedented and potentially catastrophic $40 billion deficit." Defs.' Motion 1) To Replace Receiver with a Special Master, and 2) To Terminate the Receiver's Construction Plan at 11, Jan. 28, 2009 (Docket # 2039). Even if it were possible for the construction and renovation projects to proceed despite this deficit, they would take many years to complete. As the *Coleman* and *Plata* plaintiffs have been denied their constitutional rights for fourteen and seven years, respectively, the plaintiffs cannot be compelled to await the outcome of the efforts of the Receiver, the Special Master, and/or the State for an indeterminable additional number of years.

Given that the *Coleman* and *Plata* courts have entered a number of remedial orders, we are at a loss to imagine what "other relief" short of a prisoner release order a court could grant. A "prisoner release order" is defined broadly in the PLRA as "any order . . . that has the purpose *or effect* of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison." 18 U.S.C. §3626(g)(4) (emphasis added). Many of the forms of relief that defendants and intervenors suggest, like parole reform, good time credits, and evidence-based programming intended to reduce recidivism, are designed to "reduc[e] the prison population" and thus fall under the PLRA's definition of a "prisoner release order." Others, like the implementation of the construction program contemplated by AB900, may not be within the court's general powers under the PLRA. Other forms of relief suggested by various participants are without adequate evidentiary support or appear [6] infeasible as well as incapable of curing the violations presently existing in the California prison system. We therefore tentatively conclude that there is no relief other than a prisoner release order that can remedy the constitutionally inadequate medical and mental health care in California's prisons.

3. When Congress enacted the PLRA, it contemplated that the federal courts would impose prisoner release orders only in limited circumstances. Congress, however, did not prohibit such orders,

recognizing that they would, in some cases, be the appropriate and indeed the only available remedy for unconscionable and unconstitutional conditions in the nation's prisons. Given the clear and convincing evidence presented here that crowding is the primary cause of the constitutional violations and that no other relief will remedy those violations, we tentatively conclude that the PLRA gives us the authority to issue a "prisoner release order" to reduce the overcrowding in California's prisons.

The more difficult question, in the Court's view, is the maximum level of crowding at which the State could provide constitutionally adequate care. The evidence presented provides a range of asserted operational capacities for California's prisons. We heard testimony from law enforcement intervenors that their jails begin to experience problems when the population is over 100% of design capacity. We received evidence that the Independent Review Panel chaired by former Governor Deukmejian recommended 145% of design capacity as the outside limit for California prisons generally, although that number assumed an end to the use of all nontraditional beds in programming spaces and did not specifically address services for the mentally and physically ill. We received evidence that AB 900 Facility Strike Team leader Deborah Hysen recommended that the population in any new facilities constructed under AB 900 be limited to 130% of design capacity. Plaintiffs' experts generally agreed with that number as appropriate for California prisons in general. We also heard from Dr. Pablo Stewart, a mental health expert, that some specialized clinical programs should operate at or below 100% of design capacity. In contrast, as of August

2008, California's prisons were operating at close to 200% of design capacity.

[7] Although the evidence may be less than perfectly clear, it appears to the Court that in order to alleviate the constitutional violations California's inmate population must be reduced to at most 120% to 145% of design capacity, with some institutions or clinical programs at or below 100%. We caution the parties, however, that these are not firm figures and that the Court reserves the right – until its final ruling – to determine that a higher or lower figure is appropriate in general or in particular types of facilities.

4. The PLRA directs the Court to give "substantial weight" to any "adverse impact on public safety or the operation of a criminal justice system," before issuing a prisoner release order. The parties and the Court have therefore dedicated a significant portion of the trial to this issue. It appears to us tentatively that on the basis of the evidence, a prison cap at 120% to 145% of capacity, with some institutions or clinical programs at or below 100%, could be achieved without an adverse effect on public safety. Dr. James Austin, for example, testified that such a population reduction could be implemented without adversely affecting public safety by adopting a combination of parole reform, diversion of low risk prisoners with short sentences, and good time credits. Other evidence introduced at trial also supported the view that earned credits and parole reform would have little effect on public safety, and that earned credits may even improve safety by encouraging prisoners to participate in rehabilitation programs. Evidence-based rehabilitative programming could also benefit public safety by reducing recidivism. But such

programming cannot be delivered given the present state of overcrowding.

Many of these reform measures are also supported by the State and by state officials with a commitment to ensuring public safety. The report of CDCR's Expert Panel on Adult Offender Recidivism Reduction Programming recommended a combination of earned credits and parole reform that would reduce the prison population by about 40,000 prisoners. The Governor supported a similar set of reform measures in his 2008-2009 and 2009-2010 proposed budgets, and the legislature passed a bill containing similar measures in [8] December of 2008.[2] We cannot believe that such support would exist if the adoption of such measures would adversely affect public safety. We thus infer from the universal official support for these measures that they are not likely to result in adverse public safety consequences.

The counties argue that they do not have enough funding to provide released prisoners with appropriate programming for reentry into the community. This, however, appears to be an existing problem regardless of whether the prisoners are released under the current regime or pursuant to the reform measures. More important, the Expert Panel found that, if CDCR were to adopt the recommended combination of earned credits and parole reform, it could save $803 to $906 million annually. These savings could be diverted from the current prison budget to fund community based programming, which would allow the communities to continue and expand the programs that they have described to the Court. We also note, for the benefit of the defendants, that, according to the Expert Panel's recommendation, even if a portion of the savings from population reduction is diverted to new investments in community and prison programming, California could still save between $561 and $684 million a year. It appears from these figures that the State could easily fully fund all the community rehabilitative and other programs that would implement the recommendations of its own experts without expending any funds other than those regularly provided in the prisons budget.

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[2] These documents have been presented to the Court as part of Plaintiffs' January 23, 2009 Request for Judicial Notice. The Court does not now rule on Plaintiffs' request. However, we note that we will consider any legislative enactments or proposals by the Governor as relevant evidence in these proceedings.

We emphasize that a "prisoner release order" is a broad term that is not limited to the generic "early release" program that many witnesses for the defendants and defendant-intervenors oppose. A prison cap of 120% or 145% of design capacity (or somewhere in between) could be achieved through reform measures that would not adversely affect public safety, and might well have a positive effect. This is particularly true considering that [9] California's overcrowded prison system is itself, as the Governor as well as experts who have testified before the Court have recognized, a public safety hazard.

5. Under the PLRA, any prisoner release order that we issue will be narrowly drawn, extend no further than necessary to correct the violation of constitutional rights, and be the least intrusive means necessary to correct the violation of those rights. For this reason, it is our present intention to adopt an order requiring the State to develop a plan to reduce the prison population to 120% or 145% of the prison's design capacity (or somewhere in

between) within a period of two or three years. The State has a number of options, including reform of the earned credit and parole systems, that would serve to reduce the population of the prison to whatever percentage is ultimately determined to be appropriate without adversely affecting public safety. It could also use the savings that will result from the implementation of a population cap to provide for any increased burdens on the counties. In fact, a roadmap for this type of comprehensive plan has already been laid out by CDCR's Expert Panel. This would, of course, not in any way preclude the State from constructing more facilities in the future so that its prisons could hold more inmates. We tentatively conclude, given the evidence presented to this Court, that an order imposing a cap on the prison population and requiring the State to adopt a course of action to reduce overcrowding is warranted, and that it is authorized under the PLRA.

The Court may hold a final hearing prior to issuing its final order. It will in any event ask the parties and intervenors to submit written proposals setting forth the specific percentages and dates that they believe should be incorporated into the order regarding the ultimate population cap and compliance date, as well as any interim percentages and dates they believe the Court should include in the order. The State will also be asked to specify at that time, or before, the measures it intends to adopt to ensure compliance in a manner that will best accomplish the objectives of the order, including ensuring public safety. Comments by the plaintiffs and intervenors as to these measures are invited.

Prior to the issuance of a final order the State and the plaintiffs, as well as any intervenors who choose to participate, are encouraged to engage in discussions regarding [10] joint recommendations with respect to all or any of the above matters as well as with respect to a settlement of all or any part of the dispute at issue in this proceeding. In any event, the State is directed to consult with the plaintiffs and the intervenors as to any proposed course of action that would serve to reduce the prison population. The Court will accept reports by the participants regarding any settlement that the plaintiffs are prepared to enter into with the defendants as well as with any intervenors who elect to join such settlement.

The parties and intervenors individually are each requested to advise the Court within 10 days of this tentative ruling whether they would like the assistance of a court-appointed settlement referee to aid in their discussions and, if so, whether they would have any objection to the appointment of the prior settlement referees Justice Elwood Lui and Justice Peter Siggins for that purpose.

IT IS SO ORDERED.

Dated: 02/09/09

/s/
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

Dated: 02/09/09

/s/ Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR UNITED STATE DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: 02/09/09

/s/ Thelton E. Henderson
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

EVENSON DECLARATION IN SUPPORT OF PLAINTIFFS' RESPONSE TO DEFENDANTS' POPULATION REDUCTION PLAN AND APPLICATION FOR ORDER TO SHOW CAUSE RE CONTEMPT

EXHIBIT B

[1] [Logo] CAPITOL WEEKLY

THE NEWSPAPER OF CALIFORNIA
GOVERNMENT AND POLITICS

Prisons: it's time to reform and reduce population

By Mathew Cate | 08/13/09 12:00 AM PST

Federal courts are telling California that we are out of time when it comes to reducing inmate overcrowding. The Legislature and the Governor agree that we are out of money, and have cut $1.2 billion from the Corrections budget. Now is the time for elected officials and law enforcement to come together and pass criminal justice reforms that will safely reduce our inmate population.

Inmate "early release" is a radioactive term, and something that everyone wants to avoid. Yet, a three judge court ruling issued last week seeks to impose a cap that could force the release of upwards of 40,000 inmates over the next two years. While the state will likely appeal the ruling, lawmakers should not sit idly by and leave it up to the courts. The recent riot in Chino demonstrates the perils of severe overcrowding. California needs a package of sensible prison, parole and sentencing reforms that will allow our prisons to reduce population over time without swinging open the gates for serious and violent criminals and jeopardizing the safety of our communities.

The best minds in California and the nation have already provided us with recommendations. Five years ago, the Deukmejian Commission outlined ways that we can target resources on higher risk offenders and reduce costs, without increasing crime rates. An expert panel convened by the Schwarzenegger Administration has given us a roadmap to reducing recidivism. The Administration has adopted the recommendations of both these groups in drafting its current reform proposals.

The one remaining piece of the puzzle is the passage of these population and budget reduction proposals. When the Legislature returns next week, public safety reforms must be a focal point of discussion.

Over the past several months, the Administration has worked with law enforcement stakeholders to refine a plan that we believe can reduce the prison population by up to 27,000 inmates this year, and 37,000 through 2009-10, and avert the early release that has been widely feared with the following five key components:

- Risked based parole supervision to reduce agent to parolee caseloads while maintaining law enforcement's search and seizure rights on non-serious, low-risk parolees;

- House arrest or alternative custody with GPS for elderly or infirmed inmates, or low-level offenders with 12 months or less remaining;

- Commutation to Immigration and Customs Enforcement custody of criminal alien felons who can be immediately deported to their country of origin if they're not prosecuted by the feds;

- Changing sentencing for low level offenders convicted of writing bad checks, petty theft with a prior, receiving stolen property, and vehicle theft so that they don't occupy $48,000 per year state prison beds for low-level property crimes, and raising the grand theft threshold for the first time since 1982 from $400 to $2,500; and,

- Motivating low-level offenders to complete in-prison GED, vocational, or substance abuse programs by offering up to six weeks off of the end of their sentences.

In addition to these population reduction strategies, CDCR is slashing operational costs. We are cutting over 400 positions from headquarters, reducing our programs budget by $250 million, curtailing overtime and sick leave abuse, and increasing efficiencies across the agency.

It is the duty of California's elected officials and appointed representatives of the people to make these tough decisions on budgeting for public safety resources. We cannot let the courts exert further control over our system, or allow this critical situation to worsen. With a $1.2 billion hole in our departments [2] budget that needs to be plugged immediately, and the price of inaction mounting at over $100 million a month or more, lawmakers cannot afford to wait any longer.

If California is to avoid court-ordered early release, and have the resources to keep serious, violent, and sex offenders locked up, our elected officials need to pass a sensible package of smart-on-crime bills in the coming weeks that allow us to reduce our prison population on our own terms.

[1] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

NO. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

NO. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

ORDER REJECTING DEFENDANTS' POPULATION REDUCTION PLAN AND DIRECTING THE SUBMISSION OF A PLAN THAT COMPLIES WITH THE AUGUST 4, 2009 OPINION AND ORDER

On August 4, 2009, this three-judge court issued an opinion and order finding that plaintiffs had met their burden under the Prisoner Litigation Reform Act, 18 U.S.C. § 3626, of establishing that crowding was the primary cause of the constitutionally inadequate medical and mental health care systems at issue in the underlying cases and that a prisoner release order was necessary to remedy those violations. Having determined that such an [2] order was narrowly tailored, extended no further than necessary, and was the least intrusive means possible to correct the constitutional violations at issue, we ordered defendants to present the court within 45 days, with a plan "that will in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity." Aug. 4, 2009 Opinion & Order at 183.

On September 18, 2009, defendants provided this court with a "Population Reduction Plan." The plan defendants provided does not comply with our August 4, 2009 order. Rather than reducing the population of the CDCR's adult institutions to 137.5% of their combined design capacity within two years, it provides for a reduction of the population of those institutions to 166% of their combined design capacity in that period. Additionally, defendants' plan fails to set forth effective dates for the various actions proposed and fails to provide estimates of the reduction in population they expect to achieve after six, twelve, eighteen, and twenty-four months; instead, it provides estimates of the fiscal year in which actions may take effect and estimated population reductions for each fiscal year through 2014/15. In light of these inadequacies, defendants' September 18, 2009 Population Reduction Plan is REJECTED.

Plaintiffs' response urges this court to initiate contempt proceedings against defendants on the basis of their failure to comply with our August 4, 2009 order. Action on this request is STAYED pending further proceedings detailed below.

The Court VACATES the deadline in its August 4, 2009 Opinion and Order for defendants to file a response to the objections of plaintiffs and intervenors to defendants' proposed population reduction plan. Instead, defendants shall, within 21 days of this order, submit a population reduction plan that complies with this court's August 4, 2009 Opinion and Order and that, most important, provides for a reduction of the prison population to 137.5% of design capacity within two years. Defendants are reminded that they "shall set forth in their proposal the effective dates of the various actions they propose to undertake and their estimate of the reduction in population they expect to achieve after six, twelve, eighteen, and twenty-four months." *Id*

[3] Additionally, defendants shall set forth the following in their response to this order: First, defendants shall (1) explain the calculations through which they obtained the estimates of the population reductions associated with each action that they propose; (2) identify the assumptions underlying those calculations; and (3) explain why those assumptions are reasonable.

Second, in accordance with the request of Intervenor California Correctional Peace Officers' Association, this court takes judicial notice of a September 17, 2009 press release issued by CDCR and publicly available on the CDCR website. The press release describes a reduction of $250 million in rehabilitation programs for adult offenders, and identifies that reduction as eliminating over one-third of the budget for such programs.[1] Defendants' September 18 Population Reduction Plan relies on that programming for some of its reductions. To the extent that the population reduction plan that defendants submit within 21 days of this order relies on rehabilitation programs, whether for earning credit towards release or otherwise, defendants shall explain how the September 17, 2009 budget reduction and any planned additional reductions in funding for such programs affect their estimates of population reductions associated with that plan. Additionally, defendants shall advise the court on a continuing basis of all budget reductions announced or implemented in 2009 that (1) affect the provision of medical or mental health services at CDCR's adult institutions, and (2) otherwise affect the size of the population of CDCR's adult institutions.

Third, defendants shall advise the court of the specific measures that the state will take to ensure public safety through reentry and diversionary programs, including programs provided for incarcerated inmates, post-incarceration programming, and programs for persons diverted from incarceration. The state shall catalogue and provide descriptions of current programs, including the number of persons served by each program, and shall also provide details of any programs planned for the future and the specific implementation dates [4] of such future programs. Moreover, our August 4, 2009 Opinion and

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[1] *See* Press Release, California Department of Corrections and Rehabilitation, CDCR Reduces Offender Rehabilitation Programs (September 17, 2009) available at http://www.cdcr.ca.gov/News/2009_Press_Releases/Sept_17_Programs.html (last visited October 8, 2009) (Ex. A to CCPOA Req. for Jud. Notice).

Order recognized the necessary role of community-level rehabilitation and reentry programs for ensuring the safe and successful implementation of population reduction measures, and noted that the decision lies with California's elected officials whether to allocate state funds to communities to promote and support such programs and the crime reduction and gains to public safety that accompany them. *See* Aug. 4, 2009 Opinion & Order at 164-66. Defendants shall advise the court on a continuing basis of the measures that the state is taking to support and assist counties and other community-level providers of rehabilitation and reentry programs in providing such programs, and of any steps that it may have taken or will be taking to increase, reduce, or eliminate such support or assistance since January 2009 and in each succeeding six-month period.

Fourth, the court takes judicial notice that Defendant Schwarzenegger is reported to have submitted a plan to the California State Legislature providing for a population reduction of 37,000 over two years. That such a plan was submitted by the Governor was widely reported in the press, including in an article written by Defendant Matthew Cate.[2] Defendants shall advise the court of (1) whether the plan submitted to the legislature by the Governor provided for a prison population reduction of 37,000 prisoners, and, if not, the correct estimate of the prison population reduction for which this plan provided; (2) the estimated reduction for which this plan provided in the population of CDCR's adult institutions expressed as a percentage, of the combined design capacity of those institutions; (3) the specifics of the plan submitted to the legislature, including the population reduction actions proposed therein, the date that each such action would be implemented under that plan, and defendants' estimate of the reduction in population that such a plan would achieve after six, twelve, eighteen, and twenty-four months; (4) whether this plan was adopted by the California State Senate, and, if modified, the estimated population reduction associated with [5] the plan as it was adopted by the Senate; and (5) whether, if adopted by the Senate, the plan was submitted to a vote of the California State Assembly in the form adopted by the Senate, and, if so, whether it failed in the Assembly by a formal recorded vote and what such recorded vote was. Additionally, defendants shall explain the calculations through which they obtained the estimates of the population reductions associated with each action proposed in the plan submitted to the California State Legislature; identify the assumptions underlying those calculations; and explain why those assumptions are reasonable.

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[2] *See* Matthew Cate, *Prisons: it's time to reduce and reform the population*, Capitol Weekly, August 13, 2009, available at http://www.capitolweekly.net/article.php?_c=ybp9m22r8xx2n4&xid=y6x62x72akddqo&done=.ybxkujm111kclt (last visited October 8, 2009) (Ex. B to Evenson Decl. in Supp. of Pls.' Response).

Defendants are reminded that our August 4 order provided that "should any of defendants' proposed population reduction measures require the waiver of any provisions of state law, [defendants] shall so advise the court, and shall explain why the requested waiver is permissible under 18 U.S.C. §3626(a)(1)(B)." Aug. 4, 2009 Opinion & Order at 183. Should state law limit defendants' ability to implement any measures that would, in their view, aid in achieving the constitutionally required prison population reduction explained in our. August 4, 2009 Opinion and Order, defendants shall so notify this court, and in such notification describe the specific provisions of state law at issue and explain how those provisions limit their ability to implement such measures. Even if defendants contend that state law waivers are not permissible in this instance, *see* Defs.' Sept. 18, 2009 Population Reduction Plan at 16 n.11, they must identify those waivers of state law that would be required to implement their proposals to reduce the prison population in compliance with our order.

Plaintiffs shall forthwith commence preparation of an alternative population reduction plan. Should defendants fail to submit a timely population reduction plan that complies with the August 4, 2009 Opinion and Order and with this order, this court shall, in addition to any other action it may take, order plaintiffs to provide the court within 14 days with a population reduction plan that will in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their design capacity. Should any of the population reduction measures plaintiffs propose in such a plan require the waiver of any provisions of state law, they shall so advise the court, and shall explain why the requested waiver is permissible [6] under 18 U.S.C. §3626(a)(1)(B). Intervenor California Correctional Peace Officers' Association may also submit any proposals or suggestions it may have for compliance with the August 4, 2009 Opinion and Order at such time as any population reduction plan by plaintiffs is due to be submitted, or within seven days thereafter.

This court is unaware of any excuse for the state's failure to comply with our August 4, 2009 Opinion and Order but, as noted earlier, will stay any sanctions, including possible contempt proceedings, pending defendants' response to this order. We will view with the utmost seriousness any further failure to comply with our orders. As has been made clear, this court would prefer that the state develop its own plan to meet the constitutionally required prison reduction goals explained in our August 4, 2009 Opinion and Order. We have afforded the state every opportunity to do so, even at the cost of delaying the reduction of the overcrowding of California's prisons—a reduction that is necessary to the elimination of the unconstitutional medical and mental health conditions that lie at the heart of these proceedings, and that will, in addition, significantly reduce the prison system's criminogenic effects so detrimental to public safety and welfare. Should the state again fail to submit a population reduction plan that complies with our August 4, 2009 Opinion and Order, the court will be left with no alternative but to develop a plan independently and order it implemented forthwith.

IT IS SO ORDERED.

Dated: 10/21/09

/s/ STEPHEN REINHARDT
STEPHEN REINHARDT
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

Dated: 10/21/09

/s/ LAWRENCE K. KARLTON
LAWRENCE K. KARLTON
SENIOR UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

[7] Dated: 10/21/09

/s/ THELTON E. HENDERSON
THELTON E. HENDERSON
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA

IN THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT
OF CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH
THREE-JUDGE COURT

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

PLAINTIFF'S RESPONSE TO DEFENDANTS' NOVEMBER 12, 2009 POPULATION REDUCTION PLAN

* * *

Appendix A

[1] [Seal] Office of the Governor

ARNOLD SCHWARZENEGGER
THE PEOPLE' GOVERNOR

GOVERNOR'S REMARKS

Wednesday, 08/19/2009 1:35 pm

Governor Tours the California Institution for Men in Chino

WARDEN FAKHOURY:

Good morning and welcome to the California Institution for Men State Prison, Chino Reception Center West, I'm Aref Fakhoury, acting warden at the California Institution for Men, also known as CIM.

I'm pleased to have the opportunity to be here this morning with the governor of the great state of California, Governor Arnold Schwarzenegger, along with the Secretary of the California Department of Corrections and Rehabilitation Matthew Cate and Assemblywoman Norma Torres.

Before I introduce you to the Governor, let me take a moment to thank all the CIM staff for their courageous response to stop the major disturbance here at our C-West facility on August 8th, 2009. Through staffs quick and safe response they were able to control the incident, save lives and quickly bring order back to the facility. Staffs professional commitment to duty displayed throughout this incident is a shining example of their dedication to ensure our committees are safe.

I also want to thank our Correction families for their sacrifice through these types of incidents and situations and to thank our fellow staff from responding institutions for the assistance they provided. In addition I want to thank the local law enforcement from the city of Chino, Chino Hills, San Bernardino Sherriff, city of Ontario, as well as the Chino Valley Independent Fire District, for the valuable assistance they provided in response to the incident.

And now it is with great pleasure and honor that I introduce you to Governor Schwarzenegger. (Applause)

GOVERNOR SCHWARZENEGGER:

Well, thank you very much, Warden Fakhoury, for your introduction and it's great to be here today and get a tour. Two weeks ago, as you know, these prison grounds were the scene of a tremendous amount of violence and a violent riot. It involved hundreds of inmates. Beds and mattresses were torn apart and destroyed and walls and bathrooms were destroyed. Inmates would pick up, to try to find anything they could to just hit each other, or stab each other with broken glass and so on and entire housing units were burned. It looks like a scene from one of my movies except this is a real danger here and real destruction.

A few minutes ago I had the chance of and shook hands with some of the brave men and women who entered the danger zone and restored order here. I want to thank Warden Fakhoury and Secretary Cate for taking me and also Assemblywoman Torres, on a tour here and showing us what was going on there.

Let me tell you something, they did an extraordinary job. And this is why I wanted to come here today to thank them for their spectacular job, because they did this all without the loss of a single life. Let me again thank them, to all of the staff at the California institution for Men, for their extraordinary effort and work and for their bravery. You go to work every day under the most difficult and dangerous circumstances and conditions and California appreciates the great work that you are doing and the kind of great sacrifices that you make.

Now, the riot here at Chino was a single incident. However, it is a terrible symptom of a much larger problem, a much larger illness. The reality is that California's entire prison system is in a state of crisis. It is collapsing under its own weight. Spending on prisons has nearly doubled in the last five years. We spend here in our state nearly $49,000 per inmate per year, where the national average is $32,000.

[2] And it's hard to argue that the money is spent wisely and efficiently, We have one of the highest rates of recidivism in the nation. Our prisons are overcrowded and endangering the staff and the inmates. Here in Chino nearly 6,000 inmates are in these facilities and the facilities were built only for 3,000.

And the politicians in Sacramento have swept the problem under the rug for so long California is quite literally losing control of our prisons. A federal judge has taken over the healthcare system already. Two weeks ago the federal court imposed a cap that will force the early release of 40,000 inmates.

And all of this is happening in the midst of an economic crisis that has forced us to make tough cuts also right here, not only in government but in our prisons. The budget that I signed just a month ago includes $1.2 billion in cuts and the legislature right now is debating on how to achieve those kind of savings.

Some say that the answer is to just get rid of or weaken the Three Strikes but that's not going to happen on my watch. Others say let's just open up the gates and let criminals out and roam the streets. Well, let me tell you something, this is also not going to happen on my watch, because public safety is our number one priority.

I think it's very important we must be measured and smart about how we go about and create those reductions. We must find a way to cut costs and relieve overcrowding but without sacrificing public safety. Not all criminals and not all crimes are created alike, that's very clear and this is why I have proposed and put forward a certain proposal of reforms so that we can reduce the cost of running those prisons:

- For instance, reducing parole caseload. ratios from 70/1 to 45/1, allowing us to strengthen supervision of the most serious and violent offenders;
- Or allowing certain low-risk offenders to serve the last 12 months of their sentence under house arrest with GPS monitoring;
- Or adjusting our property crime thresholds and reduce some of the 'wobblers' to misdemeanors. These are reforms that will make our communities safer, our prisons safer and give taxpayers a greater return on their investments.

And I cannot stress enough that the time for action is now. It is very important that the legislators recognize that every single day it costs us an extra $3 million if we don't have those reforms and this is why I urge Democrats and Republicans to work together and to create those reforms as quickly as possible. I know they can do it.

Thank you very much. And now I would like to bring up Secretary Cate to say a few words. Thank you.

SECRETARY CATE:

At about 1:30 in the morning on Sunday, August 9, I got the call that no secretary of Corrections wants to hear; that there's a major riot in one of the prisons. On these fields and in these dorms we had almost 1,300 inmates rioting and we had about 30 officers, 30 cops in these dorms and in those towers and on this yard.

And my primary purpose is to thank those officers for the job they did in retaking this facility. I'm very proud of the work they did under those kind of odds. They retook it one-by-one without the loss of life. They retook it one-by-one without officers being severely injured, no hostages, no deaths and I just appreciate that very much.

I want to especially thank our version of the SWAT team, our Crisis Response Team, for the work they did in going through these dorms and storming them one-by-one and retaking them for the state.

I also want to thank Director Hubbard and Assistant Director Knowles for the work they did in organizing us in these last two weeks. I think that it's really a testament to the professionalism of our staff that we sit here today with so much of this already cleaned up.

I want to thank the inspector general, who is going to review this for us and especially our law enforcement partners who surrounded this facility to ensure that no inmate escaped regardless of what was happening.

So I just have a great deal of gratitude for all of the public servants who were at work that night and in those early morning hours and the work that they did. Whether they work for the state or for the local law enforcement or the fire department, [3] they just did a great job.

The Governor is absolutely right about this crisis. There are 6,000 inmates in a 3,000-inmate facility and that makes everything we do more difficult. The Governor declared a state of emergency in overcrowding three years ago. We need action now and so with the Governor we'll be seeking reforms, the reforms that were first proposed by Governor Deukmejian in 2005 and the expert panel on recidivism reduction. Reforms will allow us to reduce overcrowding, to reduce recidivism rates.

I believe we can have a criminal justice system and a system of corrections that can one again be a leader, a national leader for inmate programs as well as safety and security. I think we can have it all; we just need to get a handle on this overcrowding issue first.

So I think we're at a turning point of this criminal justice issue and I want to say thank you to the Governor for his leadership, to Assemblymember Torres for her support in being here. Thank you to the warden for his work.

And now I'll turn it back over to the Governor for a question and answer period.

QUESTION/ANSWER:

GOVERNOR: Again, I just want to reiterate also how proud I am of Warden Fakhoury and also of Secretary Cate for the great leadership that they have provided. I was very proud of them when this whole thing took place and it actually turned out, under the circumstances, so well without any lives lost. So thank you to both of you for your great leadership.

So if you have any questions about that, please feel free.

QUESTION: We all know how expensive it's going to be to clean up; we've heard upwards of $6 million. The state budget is not in a good position, teachers are getting laid off, people are frustrated that we're having to pay that kind of money because of a riot. How do you think, how do you feel about that?

GOVERNOR: Well, I think, first of all, it will cost us money; this is very clear. And this is why it was very important and why I fought a month ago when we did our budget, that we have a reserve. Remember, the legislature left me with $156 million in the hole. This would have been the first time where we had no reserve and this is why I fought for a reserve. And that's why we have a $500 million reserve, so we can take care of things like that, or if we have fires and so on, because there are always emergencies. We have to have the money available so that we can clean up quickly and rebuild as quickly as possible and that's what we're going to do.

But it doesn't address—I just want to make sure also that you understand that it doesn't address really the larger issue. I think that the reforms will address some of the larger issues. The reality of it is, as you can see, in the last two decades we have had this mess. I mean, lawmakers and people are very quick to pass laws to be tough on crime. But every time you're tough on crime you put more people in the prisons but then where's the funding mechanism? Where are the funds, the extra funds? So what you basically do is and that's why I said earlier that we have doubled the amount of money we spend on prisons in the last five years and that means that you're taking money away from other programs.

So I think that it is very important we reform, that we reduce the prison population. We have already started doing great work by sending some of them outside the state to other prison facilities. And now we have to do some reforms and I think that will get us the savings.

Yes?

QUESTION: As your reforms are debated by the legislature there are several Republicans who feel that this is not a case of overcrowding and they have questioned and doubted that there is overcrowding. What do you say to that, specifically to your Republican colleagues?

[4] GOVERNOR: I think it's very important to recognize that, when you go to a facility like

here in Chino, that you have a facility that's built for 3,000 inmates and you have 6,000 here. That's overcrowding. No matter if you're a Republican or if you're a Democrat, that's overcrowding. And that is the case all over the state of California. We have facilities altogether that are for 100,000 inmates and we have 165,000 inmates. Its too many. That's why federal judges have now said that if we don't go and have reform and start ourselves looking at how to reduce the population that they will force us into reducing by 40,000 inmates. So we have to do something about it.

So look, I have been around. I have been going to prisons in my bodybuilding days, in the '70s, going to work out with inmates in various different prisons, basically all of the prisons all over California. So I see the difference between now and what it was then. Then there was no overcrowding. Now there is serious overcrowding and it's very, very dangerous for the staff and it's very dangerous for the inmates.

And we can do better and I think that we are going to do better now when the legislators go in there and start negotiating and creating those reforms,

Thank you very much, everybody. Thank you for coming out.

[i] Achieving a Constitutional Level of Medical Care In California's Prisons

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Thirteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action

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January 15, 2010

[ii] California Prison Health Care Receivership

Vision:

As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

Mission:

Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.

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[5] Section 1
Executive Summary

In closing the final reporting period for the year, there is much that prison healthcare stakeholders and advocates can showcase as accomplishments. While faced with unprecedented budget challenges and managing a diverse stakeholder process system, progress has continued toward attaining the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- The Receiver's Medical Classification Team has finalized the classification system and Reception Centers will begin utilizing the system on January 20, 2010 with newly arrived inmates. The Non-Reception Centers are scheduled to begin utilizing this system during the 1st quarter of 2010.

- Patient-inmate access to health care has markedly improved and, through our ongoing collaborative efforts with the Department of Corrections and Rehabilitation (CDCR), we are projecting that control of the Health Care Access Units can be transferred back to CDCR as early as next fiscal year, with a target for July 2011.

- Utilization Management (UM)—Critical to successful implementation of UM is staff leadership. The lead Nurse Consultant position was filled in September by Grace Dodd. Under Ms. Dodd's leadership interviews for UM nursing consultants have been initiated. By filling these positions, we will further enhance implementation and accountability for application of the UM system.

- The new Episodic Care Processes were tested at Mule Creek State Prison in October 2009, and the results have directly contributed to the development of draft policy to be released by December 31, 2009. The rollout of the New Episodic Care System is projected for the 1st quarter of 2010.
- Following the rollout of the Primary Care Model, the Receiver's staff conducted compliance evaluations at each institution, and each achieved 100 percent compliance with implementation requirements.
- A Request for Proposal (RFP) to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under SBX4 13, was released on October 20, 2009. A Bidders Conference was held on November 12, 2009. The selection will be announced during the next reporting period.
- Medical invoice processing activity has continued to be streamlined for efficiency through the use of Third Party Administrators (TPA) and system enhancements. The Two-Year Post Audit indentified billing discrepancies which resulted in recovering $368,835 and triggered approximately $5.6M in voluntary provider refunds.
- Significant gains have been made to meet our medical care staffing goals filling 87 percent of nursing positions and 87 percent of physician positions. (Note: Percentages have been adjusted from the prior reporting period

to account for additional nursing and physician positions to be filled that were authorized in the 2009/2010 budget.)

[6] - Quality Improvement Programs—To ensure a healthcare delivery model that is compliant, efficient and sustainable administratively and at the institutions, the Quality Improvement Program continues to lead efforts that provide for a multi-level system of checks and balances. While this report addresses all of the efforts, we highlight the ongoing audit activity by the Office of the Inspector General (OIG) and California Prison Health Care Services (CPHCS) to evaluate performance and identify opportunities to improve delivery systems; the results of the Rand study which has proposed 79 indicators to measure access to care and clinical performance, which will be incorporated into processes and systems; and the newly formed interdisciplinary Quality Management Committee charged with enterprise coordination and evaluation of the programs.

- Implementation of a pharmacy wholesaler agreement tailored to address the specific and evidentiary medical needs of patient-inmates has generated an estimated cost avoidance of $38.9M through October 2009. This coupled with improvements in pharmacy operations, based on inspection results, and the successful rollout of the GuardianRx pharmacy operating system to 29 institutions, continues to drive policy enhancements and efficiency gains at each institution.

- Upgrades to Avenal State Prison are in the final stages of completion with staff moving to the new buildings December 2009. Construction has also been completed at San Quentin. Planning activities and legal responses for the Consolidated Care Center in Stockton are proceeding in coordination with vested stakeholders.

While we continue to make strides in many important areas that bring us closer to the goal of providing a constitutional level of healthcare within California's correctional system, the momentum of these efforts has clearly been affected by the State's budget and fiscal crisis. The budget and fiscal crisis is likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core healthcare areas. However, productivity has been impacted throughout the organization, and coupled with some staff turnover, certain projects and initiatives have been delayed in their implementation. Due to these factors, this report will reflect extensions on some of the objectives and action item dates to fulfill the goals.

Moreover, although the Administration has made some proposals to the Legislature to reduce prison population and overcrowding (in part to address the state's budget crisis), so far, those proposals have not been fully embraced by the Legislature and none of them has yet been implemented. CDCR's prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care.

Format of the Report

To assist the reader, this Report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions.

   [7] Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the CPHCS website (http://www.cprinc.org/ receivermo.aspx).

2. *Appendices*: In addition to providing metrics, this report also references a number of documents that are provided to the reader in the included Appendices filed concurrently with this report.

3. Website References: Whenever possible website references are provided to the reader.

RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, we are introducing a new format that provides activity status by enterprise and by institution, as appropriate to the activity and coordination.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made toward each goal-objective-action outlined in the RTPA and the Tri-Annual Report. The Enterprise Project Deployment worksheet captures projects specifically assigned to the Receiver for broad administrative handling, analysis or testing. The Institution Project Deployment captures the status of all other activity by institution. Similar to the Percent Completed Worksheet, reporting will reflect activity that is completed, on schedule, delayed or not progressing, with corresponding dates. The Tri-Annual Report will continue to provide a narrative status report.

Due to the size of the document, the Matrix is included as Appendix 1.

[8] Section 2

The Receiver's Reporting Requirements

This is the thirteenth report filed by the Receivership, and the seventh submitted by Receiver Clark Kelso.

The Order Appointing Receiver (Appointing Order) filed February 14, 2006 calls for the Receiver to file status reports with the *Plata* court concerning the following issues:

1. All tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion of each task and metric.
2. Particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals.
3. Particular success achieved by the Receiver.
4. An accounting of expenditures for the reporting period.
5. Other matters deemed appropriate for judicial review.

(Reference pages 2-3 of the Appointing Order.)

http://www.cphcs.ca.gov/docs/court/PlataOrderAppointingReceiver0206.pdf

In support of the coordination efforts by the four federal courts responsible for the major healthcare class actions pending against the CDCR, the Receiver now files Tri-Annual Reports in four different federal court class action cases. An overview of the Receiver's enhanced reporting responsibilities related to these cases and to other Plata orders filed after the Appointing Order can be found in the Receiver's Eleventh Tri-Annual Report at pages 15-16. (http://www.cphcs.ca.gov/receiver_tri.aspx)

[9] Section 3

Status of the Receiver's Turnaround Plan Initiatives

Goal 1. Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

> *Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation.*

This Action has been completed.

> *Action 1.1.2. By January 2011, implement new processes at each of the major reception centers.*

The Reception Center redesign is planned to occur after completion of Action 1.1.3 in January 2010. Re-evaluation of the reception center processes, established in Action 1.1.1, and statewide implementation of the new processes at each of the major reception centers is expected by January 2011.

> *Action 1.1.3. By January 2010, begin using the new medical classification system at each reception center prison.*

During this reporting period, the Medical Classification System was finalized, including approval of the policy and the Medical Classification Chrono; system training of key staff; and preparation of Local Operating Procedures by Institutions. On January 20, 2010, all Reception Centers will begin using the Medical Classification System on all newly arrived inmates.

Action 1.1.4. By January 2011, complete statewide implementation of the medical classification system throughout CDCR institutions.

Non-reception center institutions will begin using the Medical Classification System during the first quarter of 2010. The Regional Leadership Teams will then begin assessing institutional compliance with the system.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on healthcare access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to already established custody posts, to ensure all patient-inmates have improved access to health care at each institution.

This Action has been completed.

[10] *Action 1.2.2. By July 2011, the Receiver will have fully implemented Health Care Access Units and developed healthcare access processes at all CDCR institutions.*

Health Care Access Units (HCAU)

All institutions have reported improvement in patient-inmate access to scheduled healthcare appointments since the last Tri-Annual Report.[1] These reported improvements indicate that inside healthcare access programs, once fully implemented, will have the necessary resources to support healthcare operations at the current level of service. Because of these improvements, and barring any regression or inability to support the field, the data suggests that operational control of custody HCAU could be transferred back to CDCR and released from Receivership control by next fiscal year (target July 2011).

Collaborative Efforts

The Corrections Services Field Operations Unit worked extensively with CDCR to reach a consensus regarding a sufficient number of additional HCAU custody staff to adequately provide access to care. These efforts sought to increase efficiencies, in view of the current fiscal issues in California, while satisfying the remaining access to care custody staff resourcing at the 33 CDCR adult institutions. This consensus with CDCR, which included a substantial increase in the number of proposed HCAU staffing from CDCR's original custody staffing reviews, was reached in October 2009.

Corrections Services continues to collaborate with CDCR mission changes and in the implementation of the short, intermediate and long term bed projects. Corrections Services continues to work with CDCR and the adult institutions to ensure that healthcare operations are not interrupted.

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[1] These reports track the efficacy of custody escort and transportation to scheduled appointments—not whether all needed appointments are scheduled.

The Receiver is continuing to work with CDCR by reviewing operational processes and staffing resources to ensure that together healthcare in prisons is safe, efficient, patient-centered, timely, efficient and equitable.

Operational Assessments

To facilitate this process, an accelerated schedule for conducting Institutional Operational Assessment reviews has been developed.

Previously, institutions were scheduled to have the Operational Assessment reviews completed by June 2010. In order to ensure the assessment instrument adequately measures intended objectives, the process review completion timeline has been extended to December 2010. Although much work remains, overall healthcare access at the institution level is on track to meet this goal.

Monthly Health Care Access Quality Report (AQR) - Data Collection Instrument

During this reporting period, AQR data stabilization continued along with the overall coordination of custody and clinical staff in an effort to track patient-inmate movement to [11] healthcare services. September's AQR indicated 90 percent of all patient-inmates that received ducat(s) for a healthcare appointment(s) were seen by a clinical provider. Specific to custody performance, the number of inmates *Not Seen Due to Custody* represented 1.24 percent of the total number of ducats, slightly lower than 1.3 percent recorded in June 2009.

Updates to the AQR during this reporting period, include the addition of Personnel Post Assignment System (PPAS) Timekeeper's Monthly Overtime and

Expenditure Report information. The new data elements record the hour and dollar figures under billing codes .08 -Medical Costs (Med Guarding), and .16 - Medical Transportation, costs that are billed to the Receiver.

The addition of those PPAS data elements and results from the testing phase for the input of AQR data into COMPSTAT necessitated further modification of the COMPSTAT data collection tool. AQR and COMPSTAT staff continues to work toward the goal of integrating the report into COMPSTAT within the coming months.

Corrections Services Field Operations Unit has established quarterly meetings with the Division of Adult Institutions, Associate Directors. On the agenda for these meetings are AQR trends, changes and updates, as well as discussions and development of other Field Operations functions and their association within elements of the DAI.

Refer to Appendix 2 for the Executive Summary and Health Care Access Quality Reports for September-November 2009.

Buses

From April 2009 through September 2009, ten (10) buses for patient-inmate transportation were distributed statewide. Efficiencies will include a reduction in the number of medical transports and backlog appointments as a result of up to 21 inmates per trip traveling to specialty appointments. Additionally, the buses allow sister institutions (HDSP/CCC) (CTF/SVSP) to utilize the same providers and batch the appointments together to make a more efficient process for both CDCR and the providers.

The Emergency Response Vehicle prototype has been completed and delivered to Avenal State Prison to complete a 4-month pilot of the unit. The Emergency Response Committee will be including the overall effectiveness of the unit into its evaluation process. All modifications will be addressed through that committee and the Corrections Services Unit. At the conclusion of the pilot, the department will assess the effectiveness, cost and purchasing of additional vehicles for all institutions.

Fair Labor Standards Act (FLSA) Validation

Since Fiscal Year 04/05, Medical Guarding and Transportation expenses have increased at a rate of approximately 48 percent each year. In order to determine the cause for increase and validate Medical Guarding and Transportation expenses, Corrections Services began FLSA validation at all CDCR institutions in December 2009. The FLSA validation process includes a review of [12] FLSA's and other billing documentation to validate overtime and temporary help expenses charged to CPHCS for 5 separate points in time at all 33 institutions. Target date for completion is March 31, 2010. The FLSA validation process will assist in confirming expenses charged and custody resources needed as part of fully implementing the Health Care Access Units.

Objective 1.3. Establish Health Care Scheduling and Patient-Inmate Tracking System

> ***Action 1.3.1. Work with CDCR to accelerate the development of the Strategic Offender Management System with a scheduling and inmate tracking system as one of its first deliverables.***

A centralized system for the scheduling and tracking of healthcare appointments, coordinated with all other appointments for patient-inmates, is an essential element of providing timely access to care. General offender scheduling and movement control within the 33 existing CDCR prisons and the planned new long-term healthcare facilities will be handled by the Strategic Offender Management System (SOMS). SOMS will include four informational components for each offender that is critical to the success of the prison healthcare system: a unique lifetime identification number; demographic information; continuous real-time location; and a comprehensive master schedule and scheduling prioritization protocol.

After the decision in summer 2009 to incorporate the healthcare scheduling functionality into SOMS, a CPHCS team of Subject Matter Experts from all areas (Medical, Nursing, Mental Health, Dental, Allied Health and Telemedicine) participated in a series of requirements definition and validation workshops. The result of these sessions culminated in the Electronic Offender Management Information System (eOMIS) Prototype and the General System Design Document which will be the foundation for the development of the healthcare scheduling system.

In conjunction with the system design activities, efforts to plan for deployment, change management, training and communication have begun. The deployment of the system will occur in phases, with the three women's institutions going first in July 2010. After a stabilization period, the roll-out will proceed to men's institutions that currently do not use technology for scheduling and then on to the remaining institutions. Roll-out of healthcare scheduling to all institutions is scheduled to be completed by the end of 2011.

Change management and training activities have been initiated beginning with the documentation of the future state business processes for scheduling, utilizing the new system. These baseline documents will provide for the development of training and user acceptance testing materials. They also serve to determine the gap between current practices and future practices in the scheduling process, thus allowing the change management team to assess the effort that will be required for training of the end users.

Communication activities included an article in the *Lifeline* newsletter and an overview PowerPoint presentation for statewide distribution and participation of the project team in various statewide calls. Feedback on the system received to date has been overwhelmingly positive.

[13] During the next few months, planning activities for the new scheduling systems will continue on multiple fronts. By growing the project team and assigning dedicated leads for change management, deployment, infrastructure and training, CPHCS will ensure that the deployment of the new scheduling system will be a success.

Objective 1.4. Establish a Standardized Utilization Management System

> *Action 1.4.1. By May 2010, open long-term care unit.*

As of October 30, 2009, the California Medical Facility Outpatient Housing Unit (OHU) Section 6.00 funds were approved by the Department of Finance authorizing the Department to use Inmate Labor to proceed with this project. Section 6.00 of the budget act allows support money to be utilized for construction projects. The scope of this project is to convert a 200 man dormitory into a 72 bed Outpatient Housing Unit. The construction adds exam rooms, nurse's stations, medication and general storage rooms, and an additional staff restroom. These additional OHU beds will be used to reduce the number of aberrant bed days that CDCR is currently encountering. Aberrant bed days are the days an inmate remains in a community hospital, discharged, awaiting placement back into a correctional institution. The cost of one discharged inmate in a community hospital bed is estimated at $4,052 per 24 hour period. This cost includes guarding and administrative fees. The OHU project is estimated to save $27 million per fiscal year.

> *Action 1.4.2. By October 2010, establish a centralized Utilization Management System.*

To maximize the impact of the Utilization Management (UM) department, clinical activities are field coordinated rather than centralized. By directly coordinating with institutional leadership, we are providing a reporting mechanism that drives accountability at the institutional level for oversight of the specialty referral activity, institutional bed occupancy and community hospital utilization, while maintaining enterprise coordination through the regional offices and headquarters.

Current central components of the UM department include:

- Oversight of specialty referral management—implementation was completed in June 2009 and continuous quality improvement activities are ongoing.

- Oversight of institutional bed availability—regular infirmary bed rounds occur in 2/3 of the regions and the Northern Region bed rounds are planned for early 2010.
- High volume community hospital bed management—hospital rounds with attending staff at high census hospitals to monitor appropriate utilization and discharge scheduling are ongoing.
- Telemedicine referral policies and processes—as the capacity of institutions to expand telemedicine services increases, transition of services from off-site to telemedicine will begin.
- Case Management of high cost, high risk patients with institutional staff, beginning with hospital case management.
- Education and outcomes reporting to Headquarters and Regional Leadership.
- Development of guidelines and assessment of new technology.

[14] UM continues to participate in the activities below:

- Claims Third Party Administrator (TPA) Payment System
- Development of a Claims Based Medical Outcomes Reporting Library
- Network Initiatives to Improve Specialist and Hospital Coverage
- Contract Initiatives to Improve Specialty Coverage in key areas and specialties

The Nurse Executive position has been hired, and, under her leadership, interviews for regional UM nursing leads have begun. Supervisory case management should commence in early 2010. This staff will be responsible for the mentoring, monitoring and training of the institutional nursing staff. Institutional bed management, community hospital discharge and case management training are planned. Their goals will be optimal institutional OHU and Correctional Treatment Center (CTC) vacancies, and the oversight of timely care and discharges of the acute community hospitalized patients. The UM nursing teams will be field based, and work in collaboration with the Physician Advisor teams. Once hospital case management is mastered, and patient data sources are developed, individual patient and patient population case management will be introduced.

As CPHCS refines its plans regarding placement of inmates in institutions that are appropriate for their medical and nursing needs, UM departmental activities will include the identification and transfer of sicker, high cost patients to those institutions close to effective specialist networks and quality hospitals with efficient care and locations It has been shown that a small percentage of high acuity patients generate a large proportion of potentially avoidable medical costs (588 high acuity patients generated over $139M in medically related costs, according to claims information from FY 2008/2009). By placing these patients, as resources permit, in institutions with closer proximity to medical resources, it is anticipated that some of the transportation, guarding and transfer costs for care can be mitigated.

[15] Goal 2. Establish a Prison Medical Program Addressing the Full Continuum of Health Care Services

Objective 2.1. Redesign and Standardize Access and Medical Processes for Primary Care

> *Action 2.1.1. By December 2009, complete the redesign of episodic care processes, forms, and staffing models.*

This action has been completed.

A test of the new Episodic Care Processes and forms began in Facility A at Mule Creek State Prison in October 2009. The test was successfully built on the structures and processes established by the Primary Care Model. Redesign of the CDCR 7362 "Health Care Services Request Form" was completed. The draft policy based on the redesign and the test site experience was completed by December 31, 2009.

> *Action 2.1.2. By July 2010, implement the new episodic care system in all institutions.*

Roll-out of the new Episodic Care System to all institutions is anticipated for the first quarter of 2010. It is anticipated that the system will be implemented at all institutions by July 2010.

Objective 2.2. Improve Chronic Care System to Support Proactive, Planned Care

> *Action 2.2.1. Implement an inter-disciplinary team-based Primary Care Model in all institutions by December 2009. Implement a Chronic Disease program within the framework of the Primary Care Model by December 2010.*

This action has been completed.

The Primary Care Model was implemented at all institutions during the previous reporting period. During this reporting period, each institution was evaluated by an on-site compliance evaluation team using a standardized methodology. All of the 33 institutions achieved 100 percent compliance with the implementation of the Primary Care Model.

Objective 2.3. Improve Emergency Response to Reduce Avoidable Morbidity and Mortality

> *Action 2.3.1. Immediately finalize, adopt and communicate an Emergency Medical Response System policy to all institutions.*

This Action has been completed.

> *Action 2.3.2. By July 2009, develop and implement certification standards for all clinical staff and training programs for all clinical and custody staff*

This Action has been completed.

> [16] *Action 2.3.3. By January 2009, inventory, assess and standardize equipment to support emergency medical response.*

This Action has been completed.

Objective 2.4. Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality

> *Action 2.4.1. By June 2009, establish standard utilization management and care management processes and policies applicable to referrals to specialty care and hospitals.*

This Action has been completed.

Specialty Referral Management and InterQual Outcomes

Areas of operational focus that continue include:

- Institutional compliance with UM processes and policies;
- Reduction of medically unnecessary referrals so that access to specialty care is optimal;
- Monitoring of backlogs and compliance with processing timelines, especially in specialty areas where network access challenges exist;
- Audits for over utilization and potential under-utilization;
- Ensuring physician and nursing inter-rater consistency in clinical decisions.

Outcomes

Specialty referral outcomes have met the Receiver's goal of 100 Referral for Specialty Services per One Thousand Inmates (RFS/K*) as illustrated in Table 1.

Table 1

RFS total		North	South	Central	Statewide	RFS/K*
Baseline FY 08/09		[illegible]	[illegible]	[illegible]	[illegible]	[illegible] 25,000
April	2009	4,525	6,674	10,023	21,222	137.19
May	2009	3,479	5,647	7,482	16,608	104.38
June	2009	3,578	4,978	8,124	16,680	109.67
July	2009	4,905	4,245	6,600	15,750	102.89
August	2009	3,875	3,708	6,477	14,060	92.46
September	2009	3,811	4,018	6,869	14,698	98.15
October	2009	3,995	4,131	6,933	15,059	97.85
November	2009	3,261	3,549	5,629	12,439	81.19

Ongoing on-site audits continue to be performed by the UM staff to ensure that denials are not "overdone" and that decreasing utilization is medically safe and appropriate.

Challenges and Threats

Personal, direct and continuous UM physician advisor and nursing support continues to be essential to sustain the improvements achieved. As these processes are relatively new to [17] CPHCS, leadership continues to engage staff in change management activities to ensure both continuity and sustainability for improved handling of Specialty Care and Hospitalization.

SBx4 13 has produced some volatility in specialty network coverage, particularly in key surgical specialty areas. Procedures to monitor access and availability are being developed, in cooperation with Regional Leadership teams, and will be a priority so that timely information regarding the need for alternative access strategies can be communicated and managed.

Infirmary / Community Hospital Bed Access

A statewide and institutional census reporting system and daily monitoring of hospital and institutional census bed occupancy began in October 2009.

Regular clinical rounds on patients in institutional infirmary beds and high volume community hospital beds are required and institutional compliance will be monitored.

While improvements in patient transfers and institutional bed vacancies have resulted, significant challenges continue. Hospital aberrant bed days (patients who have no clinical reason to stay in the hospital, but have no suitable, safe destination to return to) remain. Until enough additional beds are available, so that all hospitalized patients can return to safe institutional beds in a timely fashion, optimal hospital utilization outcomes will not be possible and unnecessary hospital days will continue to accrue and add to medical costs.

* * * *

[18] Community hospital lengths of stay reflect both a high acuity patient population and lack of institutional beds that patients can return to. While the situation is not amenable to significant improvement until additional institutional beds are available, the UM team has begun clinical monitoring of patients at 10 of the top high volume hospitals, statewide, so that the hospital census can be managed to the maximum degree possible under the current circumstances. Daily census review and collaborative discharge planning efforts with hospital case management are ongoing.

In addition to the root causes of high community hospital utilization described above, it has been found that other drivers of utilization that can be improved are common. These include: unaligned incentives to discharge promptly among community hospital attending staffs, lack of hospital case management and discharge planning, and some institutional inattention to community hospital patients.

Daily concurrent rounds at high volume hospitals are now conducted by the UM physician advisor staff. Institutional responsibility for tracking their community hospital patients and maintaining telephonic access with their high volume community hospitals and attending staffs will be mandatory. IT links to hospital medical records departments for institutional tracking of patient progress are being developed.

As UM impact on hospital bed utilization increases, benchmarks for hospital bed utilization will be established and monitoring of institutional performance will begin, similar to the process used to manage referrals.

[19] *Case Coordination*

Reports have been developed to identify the top high cost patients, statewide, who generally represent the highest acuity medical patients, at risk for frequent hospitalizations and multiple specialty referrals. The team has implemented processes to identify these patients and, through Regional leadership, share them with institutional clinical staff. The initial goal is to improve continuity of care and access to coordinated specialty care. While it is not known what impact improved clinical case coordination of these patients care could have on costs, it is intuitive that coordinated. Care coordination would mitigate lapses in continuity of treatment, and facilitate better primary care communication with outside specialists. Many of these patients are located in remote areas and would benefit from transfer in the future, as resources expand, to locations with expanded specialty and hospital coverage.

Telemedicine

Standardized referral review processes, using InterQual, have been implemented for all initial telemedicine requests. Working with the telemedicine team, additional analysis to determine which specialty areas would benefit from additional telemedicine access is planned (see Objective 5.5 for more information). It is hoped that a shift from off—site specialty referrals to on-site telemedicine referrals, as telemedicine space/equipment capacity grows, will result in additional cost avoidance for transportation and guarding, and result in improved access to care.

Referrals for Specialty Services

The following are charts that contrast the total referrals for specialty services (RFS) generated vs. the total RFSs run through the InterQual system for the northern, central and southern regions during the September 2009 through October 2009 timeframe (See Tables 4, 5 and 6 below). This program requires all RFS's to be run through the InterQual system. While the majority of RFS's are captured in this report, the following contribute to reporting exceptions: 1) the ratio between total referrals and InterQual data is closely related to system training needs and delayed reporting, captured in the following month; and 2) the difference in volume of RFS referrals is related to a number of factors including patient acuity mix, specialty network practices and requests, provider familiarity with UM processes, provider staff turnover, strength of the institutions primary care model, and the acuity of physician reviewer oversight. (Note that these differences mirror referral practices in the civilian sector.) As UM becomes more engrained into institutional processes and reviewers gain familiarity with the InterQual system, we anticipate minimal differences among the regions.

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[21] This action item is ongoing. Progress during this reporting period is as follows:

ProdÁgio Contract Processing System

Implementation of an upgrade to an automated contracts process system is scheduled to take place in January 2010. This upgrade will deliver enhanced processing features including auto-filing of contract documents, and an analyst time-tracking feature. This additional functionality will aid in effective contract processing until CDCR's Business Information System (BIS) system is implemented for direct medical contracts (see "CDCR's BIS Integration" below). A number of medical contract staff participated in Train-the-Trainer and User Acceptance Testing of the upgrade features in December 2009.

CDCR's BIS

CPHCS is continuing its participation in work groups and demonstrations organized by the CDCR BIS Team. In addition, CPHCS will begin the process of defining how Medical Contracts will integrate BIS into its business process.

Streamlining Medical Contracting and Aligning Resources to Achieve Performance Goals

To the greatest extent feasible, medical contracts are now entered into as a statewide master, regional, or joint contracts, rather than on an institution-by-institution basis. This contracting methodology significantly streamlined CPHCS' ability to provide greater patient-inmate access [22] to care. From August 17, 2009, through December 9, 2009, 100 new negotiated contracts and 20 amendments to negotiated contracts were executed for hospitals and specialty physician services. In addition, competitive bid efforts initiated in the previous reporting period resulted in 36 competitively bid contracts and 18 amendments to competitively bid contracts for a variety of services.

The Request for Proposal (RFP) to obtain a medical services network from a PPO, as allowed under the new legislation (SBX4 13 which amended Penal Code section 5023.5), was released October 20, 2009. The Bidder's Conference was held on November 12, 2009.

The selection will be announced during the next reporting period.

During the reporting period, CPHCS Medical Contracts initiated or completed the following contract negotiations with ambulance providers: ten in the Northern Region, two in the Central Region, and seven in the Southern Region. A total of 24 ambulance contract negotiations were initiated and 19 ambulance contract negotiations were completed. There were seven invitations to bid advertised and two bid openings during the reporting period.

Medical Contracts continues to work closely with the Receiver's Emergency Medical Services Liaison, county Emergency Medical Services throughout the state, and ambulance associations and providers to enhance customer relations and emergency medical contract processes.

Hospital Rate Negotiations

Since the passage of SBx4 13, staff has successfully negotiated statutory rates (including the exempted administrative days) with 24 hospitals. Thirty nine (39) contracts have been executed with hospitals that have agreed to the new rate structure. Only one long term hospital partner, Community Regional Medical Center in Fresno, has discontinued service due to the lower rates. However, there are a couple of hospitals, including the three University of California (UC) hospitals, which are continuing to see patients without a contract in place at the non-contracted rate of 100 percent of Medicare. While concerns about the rates have been raised by these hospitals, CPHCS will continue to work with the providers to execute service contracts at the statutory rates stipulated in SBx4 13 to ensure a consistent and equitable rate of reimbursements for services rendered by agreement/contract for all providers. See Appendix 3 for the California Hospital Map, a color coded map indicating coverage throughout the State.

> *Action 2.4.3. By November 2009, ensure specialty care and hospital providers' invoices are processed in a timely manner.*

Medical Invoice Processing Days

During this reporting timeframe, the number of invoices processed per day has increased. This has resulted in a decrease in the number of invoices waiting to be processed. With that, we expect to see a decrease in overall days to process in the first quarter of 2010. Due to the transition of a subset of the invoices to the TPA as discussed in the next section, metrics on both areas will be reported in the next Tri-Annual Report to the Court.

[23] *Contract with the Third Party Administrator (TPA)*

The full transition of claims submitted on industry standard fauns (hospital, physician, and ambulance) to the TPA began on October 5, 2009 for dates of service September 1, 2009 forward. The electronic interface between the TPA, BIS and the State Controllers Office is successful and working smoothly. The average days to process for the TPA claims will go live January 7, 2010.

The eligibility interface between the TPA and the Offender Based Information System is expected to go live in early 2010. This will reduce the TPA processing time by several days. Additionally, a Provider Web Portal, that will allow providers to access their explanation of benefits information directly, will be included with this interface. This will help reduce operations workload further by shifting payment inquiry research to providers through this portal.

Two-Year Post Audit

Viant has performed their audit of the two largest laboratory providers and their initial findings will be presented to staff in January 2010. In addition, they continue to contact providers for recovery based upon their findings of duplicates and hospital bill audits. As of December 8, 2009, their recovery effort has netted $368,825 in refunds. Their payment for this effort is 27 percent of that amount. In addition to Viant's recovery efforts, as of December 8, 2009, staff has received approximately $5,647,671 in voluntary provider refunds. These voluntary refunds are in part due to staff identifying duplicates and overpayments as part of their data cleanup and have been contacting providers directly for refunds. In addition, providers are sending duplicates and overpayments back to balance their Accounts Receivable due to their knowledge of the audit.

TPA/Contract Medical Database (CMD) Interface

The TPA to CMD interface workgroup has adopted system requirements and has met regarding initial design and development of that interface. The interface will push down utilization and expenditure data from the TPA into the CMD. This is necessary to be able to accurately report on the effect of the cost containment initiatives as well as prepare for contract medical budget projections. This interface (Phase 1) is expected to roll out by the end of February 2010. The second phase of this project will be to expand the data elements not currently collected by CMD to include clinical line item detail.

[24] Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1. Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

> *Action 3.1.1. By January 2010, fill 90% of nursing positions.*

As of November 30, 2009, which is the most recent reporting period available, approximately 87 percent of the nursing positions have been filled statewide (this percentage is an average of six State nursing classifications). It should be noted that while there is a decrease in the percentage of filled nursing positions since the 12th Tri-Annual report, this is due to the fact that an additional 58.8 nursing positions were authorized in the 2009/2010 budget and are reflected in the November Human Resources Recruitment and Retention Report, adjusting the percent comparison.

More specifically, the goal of filling 90 percent of the Registered Nurse (RN) positions has been achieved at 18 institutions (54.5 percent of all prisons). Eleven institutions (33.3 percent) have filled 80 to 89 percent of their RN positions. The goal of filling 90 percent of the Licensed Vocational Nurse (LVN) positions has been achieved at 15 institutions (45.4 percent) and 14 institutions (42.4 percent) have filled 80 to 89 percent of their LVN positions. Twenty-two institutions (66.6 percent) have achieved the goal of filling 90 percent of their Psych Tech positions. Four institutions (12.1 percent) have filled 80 to 89 percent of their Psych Tech positions.

The following hiring-related initiatives continued during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2)

presentations at nursing schools statewide; and (3) online job postings. Nursing vacancies are posted on multiple websites including: www.ChangingPrison HealthCare.org, www.Indeed.com, www.VetJobs.com, and several more. Each job posting often represents multiple vacancies at an institution. Additionally, staff recently negotiated a contract with www.Mon ster.com for job postings on that site. Staff has been assigned to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

At the following institutions: Richard J. Donovan Correctional Facility, California Correctional Institution, Wasco State Prison, Pleasant Valley State Prison, and California State Prison, San Quentin, nursing has experienced moderate turnover (11 to 19 percent) and moderate vacancies (11 to 30 percent vacant) as displayed in the Nursing Filled Percentage and Turnover Rate map in the November Human Resources Recruitment and Retention Report. A moderate vacancy rate (11 to 30 percent) exists at Chuckawalla Valley State Prison, California Men's Colony, Kern Valley State Prison, North Kern State Prison, Correctional Training Facility, California State Prison Corcoran, Substance Abuse Treatment Facility, Valley State Prison for Women, Sierra Conservation Center, Deuel Vocational Institution, California Medical Facility, and Pelican Bay State Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2009. [25] These reports are included as Appendix 4. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and

Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

> *Action 3.1.2. By January 2010, fill 90% of physician positions.*

Physician recruitment efforts continued to focus on "hard-to-fill" institutions during the reporting period. Most urban institutions have now hired their full complement of primary care providers. As of November 30, 2009, approximately 87 percent of physician positions are filled (this percentage is an average of all three State physician classifications). More specifically, 94 percent of the Chief Medical Officer (CMO)/medical executive positions are filled; 80 percent of the Chief Physician and Surgeon (P&S) positions are filled; and 87 percent of the P&S positions are filled. Eighteen institutions (54.5 percent) have achieved the goal of filling 90 percent of their P&S positions; 15 of these institutions have filled at least 95 percent of their P&S positions. Six institutions (18.2 percent) have filled 80 - 89 percent of their P&S positions. It should be noted that while there is a decrease in the percentage of filled P&S positions since the 12th Tri-Annual report, this is due to the fact that an additional 12.5 P&S positions were authorized in the 2009/2010 budget and are reflected in the November Human Resources Recruitment and Retention Report. While the Central Valley region, along with High Desert State Prison, Pelican Bay State Prison, and Chuckawalla Valley State Prison continue to be "hard-to-fill," P&S hires have been made at the Substance Abuse Treatment Facility, High Desert State Prison, Chuckawalla Valley State Prison, California Correctional Institution, and California State Prison, Corcoran. Of special note, California State Prison, Corcoran has now filled 96 percent of their P&S positions.

Job postings continue to be placed online at the Department's recruitment website, other online job boards, and recruiters continue to visit residency programs and other recruitment events. Additionally, staff has drafted a RFP for physician and executive search services. These services would be used to assist with staffing the "hard-to-fill" institutions.

A high vacancy rate (50 to 55 percent) and turnover rate (33 to 40 percent) exist at Pelican Bay State Prison, Salinas Valley State Prison, Chuckawalla Valley State Prison, and Avenal State Prison, as displayed in the Physicians Filled Percentage and Turnover Rate map in the November Human Resources Recruitment and Retention Report. A high turnover rate (16 to 33 percent) also exists at High Desert State Prison, Central California Women's Facility, California Men's Colony, Ironwood State Prison, and California State Prison, Los Angeles County. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for September, October, and November 2009. These reports are included as Appendix 4. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

[26] *Objective 3.2.* Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2010, establish and staff new executive leadership positions.

Action 3.2.2. By March 2010, establish and staff regional leadership structure.

The Chief Executive Officer (CEO) examination was launched on December 24, 2008. Since the exam commenced, 339 CEO eligible applicants have been added to the certification list and four hires have been completed. Due to the severity of the State's fiscal crisis, the Department of Personnel Administration (DPA) has approved a reduction in the salary structure for the CEOs to more closely approximate that of the institutional wardens; however, a differential for hard to recruit or high cost areas and the performance incentive features were retained as additional means of compensation. The pool of CEO candidates is very competitive and interest remains high.

Strategically, CEO positions will be filled statewide and these individuals will then play a pivotal role in establishing the remainder of the clinical leadership structure. The interview and hiring process for all CEO positions is underway, and several hires are pending.

The Receiver's Nurse Executive examination was launched in September 2008. Since the examination commenced, 247 Nurse Executive eligible applicants have been added to the certification list and nine Nurse Executives have been hired.

The Receiver's Medical Executive examination was launched in December 2008. Since the examination commenced, 83 Medical Executive eligible applicants have been added to the certification list and nine Medical Executives have been hired.

On September 3, 2008, the State Personnel Board (SPB) approved a fourth Receiver's Career Executive Assignment (RCEA) classification, entitled Clinical Executive that is intended for the chief and assistant chief responsible for all licensed allied health disciplines. The civil service examination for this classification was released on November 4, 2009, and DPA has issued the pay letter. An organizational structure has been approved by CPHCS executive management and recruitment is in progress for five of the listed specialties: rehabilitation, laboratory, radiology, respiratory, and dietary services.

A fifth RCEA, Receiver's Health Care Administrator, that will be responsible for all medical administration subject areas that are not clinical in nature, is scheduled for approval by SPB on December 17, 2009. Prior to filling jobs covered by this classification, a salary study must be conducted and salaries approved by DPA.

In an October 2009 hearing, CPHCS staff reported to the five member SPB on the status of the delegation for the establishment of CEA positions. Staff noted that the delegation did not reduce the time or paperwork needed to establish CEAs. Given that the number of new CEA requests has diminished significantly, CPHCS staff requested that the delegation agreement be discontinued. Additionally, CPHCS currently has an arrangement with DPA whereby CPHCS [27] funds a position that is dedicated solely to CPHCS workload. This arrangement will be assessed on a continual basis to determine the ongoing need.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new health care hires.

Status of New Employee Orientation and Training

Health Care New Employee Orientation (HCNEO) was placed on hold regionally with the exception of Headquarters during February 2009. During this time CPHCS employees in the field (institution and regional) were directed to attend the local institution IST NEO until the statewide re-implementation could be coordinated. A recent audit, however, identified a large number of healthcare new hires who had not attended any orientation. The primary issue of inconsistency with the IST NEO from one institution to the next was instrumental in the development and roll-out of the HCNEO curriculum. The program will begin in January 2010 at the institution-level for all healthcare staff to include Medical, Dental, Mental Health, and support staff located in the field; and the curriculum is consistent statewide. Headquarters staff continues to receive training on a monthly basis in the greater Sacramento area. In addition, portions of the training continue for out-of-state patient-inmate providers via a computer-based training program. Success of this overall program relies heavily upon collaboration with CDCR and CPHCS staff locally and at Headquarters. The next tri-annual report will provide an analysis of how the training is being implemented and received.

Status of the Proctoring / Mentoring Program

Implementation of a proctoring/mentoring program was put on hold at the end of February 2009. The plan for proctoring and mentoring is being revised so that fewer resources are required to implement and maintain.

Action 3.3.2. By January 2009, win accreditation for CDCR as a CONTINUING MEDICAL EDUCATION provider recognized by the Institute of Medical Quality and the Accreditation Council for Continuing Medical Education.

This action has been completed.

During this reporting period, the Continuing Medical Education (CME) courses (listed below) were conducted for a total of 40 sessions at various institutions throughout the department. These sessions were provided to 195 MDs and 247 non-MDs for a total of 3,354 hours of instruction.

- 2009 Program Guide Training (Mental Health)
- Advance Directives

At this time, the following eight CME courses are in various stages of development, review, approval and/or implementation.

- CPHCS Pain Management Guidelines
- Low Back Pain/Acute Joint Pain
- [28] Do Not Resuscitate/POLST
- Diabetes
- Mental Health Assessment and Referral Project Training
- HIV Medicine for the Primary Care Provider
- CPHCS HIV Update 2009-2010
- Introduction to the MHSDS for Medical Staff

As a continuous effort to improve inmate-patient healthcare, the Office of Professional Education and the CME Committee continue to work with other programs to assess the educational needs of CPHCS/CDCR clinicians. To fully embrace the multi-disciplines within CPHCS/CDCR, in addition to physicians and surgeons, the CME Committee includes representatives from mental health, dental and nursing.

[29] Goal 4. Implement Quality Improvement Programs

Objective 4.1. Establish Clinical Quality Measurement and Evaluation Program

> *Action 4.1.1. By July 2011, establish sustainable quality measurement, evaluation and patient safety programs.*

During this reporting period, RAND completed their in-depth analysis of correctional and free world health system quality measures. In October 2009, the principal investigators presented their findings to CPHCS executives. The final 79 performance measures, selected by a panel of national experts, were a mix of process and outcome measures that were virtually all based on evidence from research and/or accepted national standards (e.g., HEDIS measures). The Measurement and Evaluation Unit will focus analysis on outcome performance measures because of their immediate impact upon the health of our patients and the resources needed to care for them. The Unit will work with clinical leadership to embed the outcome measures into clinical guidelines and other decision support tools; professional development and training programs; and patient self-management tools. The intended result will be reduced patient morbidity and mortality and reduced resource burdens statewide.

The Measurement and Evaluation Unit also continued the development of a data collection and reporting infrastructure to support their analysis of outcome indicators. This included support for the Clinical Data Repository (CDR) and the development of accurate medical chart review capacity and methodologies. With this infrastructure in place, the primary care teams and management will be able to be more efficiently inform patient care. Unit staff continued their support of clinical staff in the implementation and evaluation of several system-wide initiatives. One example was the full implementation of the primary care model to all 33 institutions. Complementing these initiatives was a request by executive leadership for the Unit staff to lead a high priority data validation study on a number of "access to healthcare" measures. The findings from this study will be used to improve patient health oversight and prompt the refinement of the department's data collection procedures.

Action 4.1.2. By July 2009, work with the Office of Inspector General to establish an audit program focused on compliance with Plata requirements.

This Action is divided into two phases. Phase I included program development and pilot implementation, and Phase II included statewide roll-out and implementation. Phase I is complete and Phase II is well underway.

As of the close of this reporting period, the OIG has completed five additional inspections at High Desert State Prison, California Correctional Center, North Kern State Prison, Kern Valley State Prison, and Folsom State Prison, respectively. The first year inspection results will establish a baseline that will provide an objective, clinically appropriate method to evaluate and monitor the progress of medical care delivery to patient-inmates within each institution. Once final inspection reports are issued, the inspection results for each institution will be available to be viewed on the OIG website (http://www.oig.ca.gov).

[30] The OIG activated its second team in December 2009. Inspections will proceed at a rate of one inspection per team each month. With two inspections per month, they are on target to complete medical inspections of all the institutions by fiscal year end, thus completing Phase II.

During this reporting period, the Program Compliance Section (PCS) completed six 180-day follow-up reviews at California Medical Facility, RJD Donovan Correctional Facility, Centinela State Prison, Deuel Vocational Institution, California Correctional Women's Facility, and California Men's Colony. The 180-day follow-up reviews focused on those areas where the institution stated corrective action of the OIG findings had been fully implemented. The PCS also completed its first 360-day follow-up review at California State Prison, Sacramento. The 360-day follow-up review focused on those areas not fully implemented and areas found to be non-compliant during the 180-day review. These follow-up reviews will provide the necessary monitoring to ensure progress continues towards a system of adequate medical delivery for patient-inmates.

Objective 4.2. Establish a Quality Improvement Program

Part of the Quality Improvement Program has been the implementation of a Credentialing and Privileging Program. The Program contains both a formal committee and a support unit to process all initial and reappointment medical staff applications, while ensuring all providers have adequate and current credentials.

Credentials Committee

During the reporting period of September 1, 2009, through November 30, 2009, the Credentials Committee reviewed 44 individual provider cases. Of the 44 cases reviewed, 16 were approved, 9 denied, 17 reviews resulted in either a Credential Alert or a Credential Bar, and 2 are pending a final determination.

Credential Applications

Within this reporting period, the Credentialing and Privileging Unit staff processed 508 credential applications. Of these, 373 were approved, 10 denied, 30 were closed due to being incomplete, and 95 files are pending completion.

Two-Year Reappointment Compliance

During the reporting period of September 1, 2009, through November 30, 2009, 220 civil service and 15 registry providers were notified to complete their two-year reappointment. Of these 235, 73 have been completed while 162 remain pending completion. Of the 162 pending reappointments, 57 are not due until January 2010, 9 are currently being processed by the Unit staff, leaving the remaining balance of 96 pending due to provider compliance.

The previous reporting period reflected that 230 reappointments were pending completion; however, further internal auditing shows a total of 280 reappointments that were pending completion. Of the 280, 82 have been completed leaving 198 still pending. Of those 198, 11 are pending completion by the Unit staff and 187 are pending provider compliance.

[31] To date, 360 reappointments are pending completion with 78 percent due to provider non-compliance. The two-year reappointment credentialing requirement is a condition to continue providing clinical services to the Department. Due to the non-compliance of provider completion, the Unit management has addressed the need for regional and institutional management to administratively direct the providers to comply. Beginning January 2010, the Credentialing and Privileging Unit staff will provide monthly compliance reports to the Executive Leaders to assist in achieving statewide compliance.

Tracking of License and Board Certification Expirations

The reporting period for Licensure Expirations is September 1, 2009 through November 30, 2009. The Licensure Expiration process has yet to be completed for the month of December. During this reporting period 79 Notice of Licensure Expirations were processed and renewed. To date all monitored provider's license are current through November 30, 2009. There were no Board Certification Expirations during this reporting period. The tracking of expiring license and certifications is an on-going process with notifications being sent out regularly to ensure that the practitioners have active, current credentials and/or licenses at all times.

Backlog and Delays in Processing

The number of pending files is once again at an all time high. The furlough program continues to impact turn around times for completing provider files and activities. In an effort to decrease the turnaround timeframe for final committee decisions, the Credentials Committee resumed weekly meetings in November 2009.

> *Action 4.2.1. (merged Action 4.2.1 and 4.2.3): By January 2010, train and deploy existing staff—who work directly with institutional leadership—to serve as quality advisors and develop model quality improvement programs at selected institutions; identify clinical champions at the institutional level to implement continuous quality improvement locally; and develop a team to implement a statewide/systems-focused quality monitoring/measurement and improvement system under the guidance of an interdisciplinary Quality Management Committee.*

During this reporting period, the Quality Improvement Section was reorganized and the objective actions have been revised. The new plan for the Quality Management Improvement (QMI) program will include a small headquarters team of clinicians supported by analytical staff dedicated full-time to state-level oversight, monitoring and training functions. They will coordinate and evaluate statewide and systems-focused quality improvement activities under the guidance of an interdisciplinary Quality Management Committee (QMC).

Regional QMI leadership will be coordinated by existing nursing and physician staff who travel to the institutions on a regular basis to monitor and address a variety of issues and who maintain ongoing relationships with institutional healthcare leaders. These staff will work closely with quality improvement teams and clinical champions at each institution. To achieve this action, state-level, regional and institutional staff from throughout CPHCS will be trained by January 2010 with the goal of full deployment and statewide implementation by June 2010.

[32] In addition, during this reporting period a joint interdisciplinary QMC (encompassing medical, mental health and dental issues) has begun to meet on a regular basis. The QMC has met a total of five times to provide direction to the QMI work plan, with an initial focus on measurement of healthcare quality processes and outcomes. The interdisciplinary Clinical Guidelines Committee, which reports to the QMC, continues to meet and has made adjustments to and adopted national guidelines on diabetes care. The identified best practices and approved guidelines will be used as a basis for development of training and medical education programs and tools to support quality improvement at the institutions.

> *Action 4.2.2. By September 2009, establish a Policy Unit responsible for overseeing review, revision, posting and distribution of current policies and procedures.*

This Action has been completed.

During this reporting period, the Policy Unit coordinated the development and statewide distribution of four new policies. Policy Unit staff also finalized 13 related medical forms, which institutions may now order through CDCR. A total of 11 policies were submitted to the Policy Unit during the period. One entire volume of the Inmate Medical Services Policies and Procedures was updated by the end of the reporting period.

Policy Unit staff identified a test institution site for statewide implementation of a policy tracking system and is coordinating implementation with Health

Care Information Technology staff and the Project Management Office.

Action 4.2.3. By January 2010, implement process improvement programs at all institutions involving trained clinical champions and supported by regional and statewide quality advisors.

This Action has been combined with Action 4.2.1.

Objective 4.3. Establish Medical Peer Review and Discipline Process to Ensure Quality of Care

Action 4.3.1. By July 2008, working with the State Personnel Board and other departments that provide direct medical services, establish an effective Peer Review and Discipline Process to improve the quality of care.

This Action has been completed.

The Professional Practice Executive Committee (PPEC) and Peer Review Subcommittee met 13 times during the reporting period and have reviewed a total of 83 civil service referrals. The Peer Review Subcommittee closed 26 referrals following review or the successful results of training and/or monitoring plans, of which 13 new plans were implemented. The Governing Body approved six case closures of providers whose clinical practice was deemed to meet an appropriate standard of care following a peer review investigation.

[33] In this reporting period, the PPEC summarily suspended the privileges of two providers, while three providers separated from State service following a referral. The Governing Body also issued Notices of Final Proposed Action under the new policy to revoke privileges and employment of one physician. Graphical displays of PPEC outcomes for

the period September 2009 through December 2009 are presented in the Tables 7 and 8.

* * * *

[34] While the PPEC's primary charge is providing for patient safety, PPEC is also charged with supporting physician practice improvement. With an improving physician and mid-level workforce, the PPEC can increasingly focus efforts on remediation and practice improvement while still providing for increased patient safety. During this reporting period, the number of referrals and summary actions has decreased while case closures, training, and remedial activities have increased.

In a continued effort to ensure physicians are afforded their due process rights in a timely manner, CPHCS has taken affirmative steps to implement the entire disciplinary process including formal hearings. During this reporting period, there were no formal appeal hearings before a Judicial Review Committee. In the next reporting period, CPHCS will work collaboratively with SPB to transition the appeal hearing process from hearings at the Office of Administrative Hearings to the SPB.

In a healthcare organization, the Governing Body is the highest policy making body for the provision of healthcare. Consistent with community standards and healthcare organization, the Governing Body is responsible for the administration, direction, monitoring, and quality of healthcare services provided to inmate-patients within CPHCS and Division of Correctional Health Care Services (DCHCS) adult institutions. The Governing Body takes final action on recommendations from the PPEC regarding practitioners.

During this reporting period, the Governing Bodies for CPHCS and DCHCS were combined into one Governing Body. This merging brought together the medical Governing Body (responsible for the practice of physicians, nurse practitioners and physician assistants) and the mental health and dental Governing Body (responsible for the practice of psychiatrists, psychologists, licensed clinical social workers and dentists). The newly reconstituted Governing Body has met monthly since October to act on the recommendations of the PPEC.

Objective 4.4. Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations

> *Action 4.4.1. By January 2009, fully staff and complete the implementation of a Medical Oversight Unit to control and monitor medical employee investigations.*

[35] This action has been completed.

The Medical Oversight Program (MOP) has utilized an alternative operational approach that meets the key program objectives in an efficient and cost effective manner. The MOP has realigned clinical resources regionally, utilizing both CPHCS headquarters and regional clinicians as MOP team members in order to maximize the clinical resources. This approach was implemented to utilize physicians and nurses as subject matter experts in medical investigations while also utilizing their clinical expertise in a variety of initiatives for CPHCS.

During this reporting period, MOP has developed the first draft of policies that will govern the program operations. The policies will be reviewed by key stakeholders from CPHCS and CDCR for input prior to finalizing the draft during the next reporting period.

CPHCS clinicians and the Office of Internal Affairs are working collaboratively to develop a process for the MOP Chief Medical Officer (CMO) and MOP Chief Nurse to pre-screen "Confidential Request for Internal Affairs Investigation/Notification of Direct Adverse Action." The aim of this endeavor is to ensure medical experts are involved in the review processes at the earliest stage necessary to expedite medical investigations.

MOP activations continue to review the most egregious of sentinel events. During this reporting period, the MOP was activated for eight cases. Four of these cases were submitted by institutional healthcare managers and four were called by the MOP CMO. The Medical Intake Panel convened and opened four cases for investigation, rejected nine cases for investigation, and five cases are pending further review. With respect to the disposition of cases reviewed by the Panel, four "Direct Actions" were referred back to the hiring authority, eight subjects were referred to Nursing Practice Review and one subject was referred to the PPEC.

Graphs of MOP outcomes for September—December 2009 are in Tables 9 and 10.

* * * *

[37] *Objective 4.5.* Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative

> *Action 4.5.1. By July 2008, centralize management over all healthcare patient-inmate appeals, correspondence and habeas corpus petitions.*

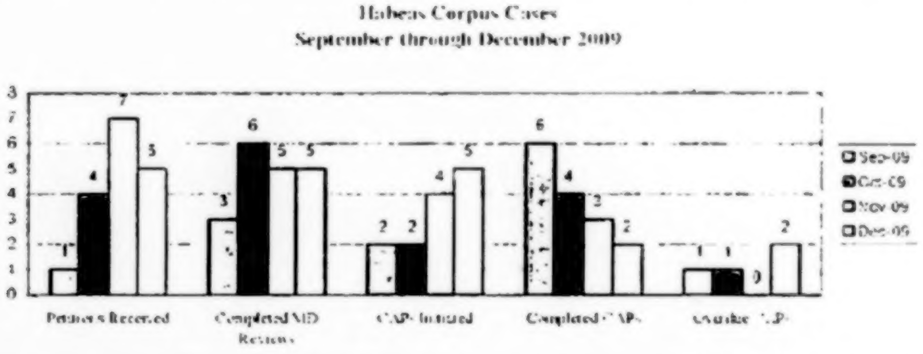
This Action has been completed.

Habeas Corpus Petitions

The volume of Habeas Corpus petitions received remains inconsistent from month to month (e.g. in March 2009, eleven were received and in September 2009, one was received). However, an average of six petitions was received each month since late 2008. During this reporting period, an average of four habeas corpus petitions were received; an average of three Corrective Action Plan (CAP)s were initiated; an average of four CAPs were completed; and an average of one CAP was overdue.

Table 11 displays the habeas corpus petitions for September through December 2009.

Table 11



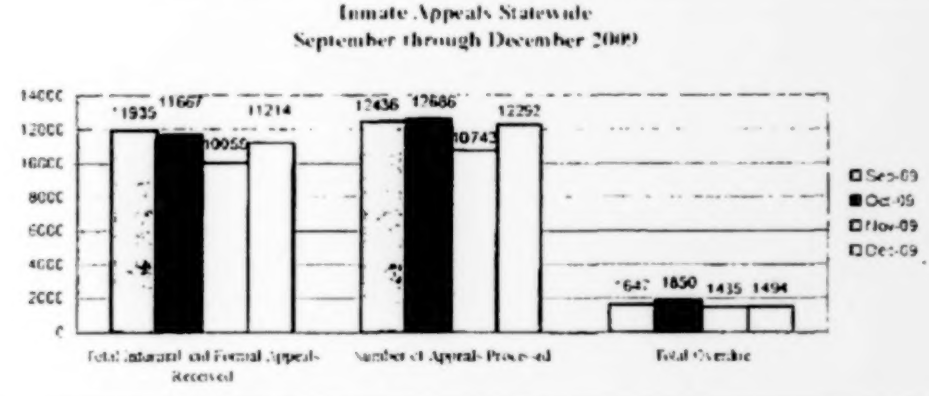
Institutional Health Care Appeals

During this reporting period, the monthly average of healthcare appeals received at institution healthcare appeals offices decreased from 12,369 during the prior reporting period to 11,220. The monthly average of all healthcare appeals processed at institutions decreased from 13,183 during the prior reporting period to 11,955. However, the monthly average of overdue appeals statewide increased from 1,467 during the last reporting period to 1,644.

Table 12 displays data related to Health Care Appeals Statewide for September through December 2009.

[38]

Table 12



Office of Third Level Appeals-Health Care

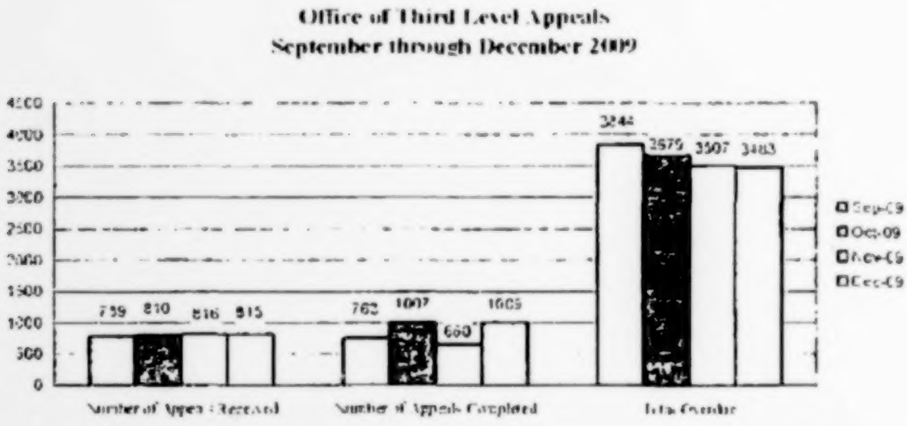
On August 1, 2008, the Office of Third Level Appeals (OTLA) began receiving all third level appeals regarding healthcare issues that were previously processed by CDCR. Due to the higher than anticipated volume and a necessary clinical review, there continues to be a significant and growing number of overdue appeals. In an effort to address this, a re-engineering analysis was recently completed to streamline the OTLA processes. Additionally, some staff have been redirected from other departments within CPHCS and overtime is approved to assist in alleviating the backlog of overdue appeals. A variety of significant OTLA work process improvements have been initiated since July 1, 2009, to continually increase the number of appeals closures with a goal to eliminate the overdue appeals by April 1, 2010. These efforts have significantly increased the number of appeals closure as evidenced below:

8/1/08-6/30/09 (11 months) of 3,765
7/1/09-11/30/09 (5 months) of 3,741

Further, a new plan of action to process all of the overdue appeals will be initiated on January 4, 2009. All of the overdue appeals will be screened and triaged by management and clinical staff to determine if the lower level appeal response is complete and appropriate, and if so, the lower level responses will be adopted. However, if the lower level response is incomplete or inappropriate, staff will complete an abbreviated medical records review and clinical summary prior to completion of the response. Meanwhile, all new appeals will be processed to prevent any additional overdue appeals which will provide data to determine if the current staffing resources are sufficient to keep up with the incoming workload. Both action plans to address the backlogged appeals and new incoming appeals will involve a management and clinical "triage" review to identify administrative and critical/chronic care healthcare appeals.

[39] Table 13 displays data related to OTLA for September through December 2009.

Table 13



Action 4.5.2. By August 2008, a task force of stakeholders will have concluded a system-wide

analysis of the statewide appeals process and will recommend improvements to the Receiver.

This Action has been completed.

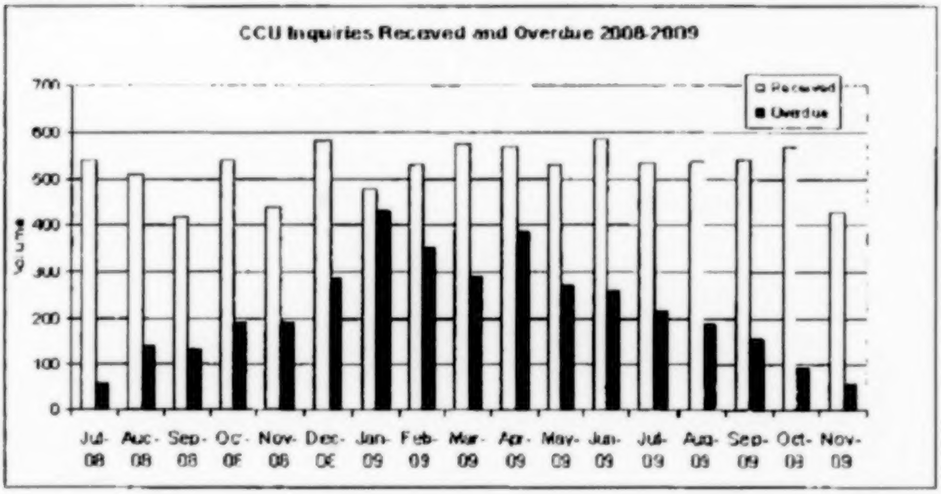
Controlled Correspondence and Litigation Support Unit (CCLSU)

Additional staffing for a new Controlled Correspondence team to address the increased workload has been added. Overdue responses spiked in January 2009 to a high of 430, but with the increased staff and a limited amount of overtime, overdue responses have trended downward for the past seven consecutive months to 61 overdue cases by the end of November 2009. In addition, policies and procedures were reviewed and revised to streamline CCLSU processes. At the current rate of progress it is anticipated CCLSU will eliminate their backlog by the next reporting period. The CCLSU Executive Summary Reports for September-November 2009 are attached as Appendix 5.

See Table 14 regarding the tracking of CCLSU incoming inquiries and overdue responses.

[40]

Table 14



Objective 4.6. Establish Out-of-State, Community Correctional Facilities (COCF) and Re-entry Facility Oversight Program

> *Action 4.6.1. By July 2008, establish administrative unit responsible for oversight of medical care given to patient-inmates housed in out-of-state, community correctional or re-entry facilities.*

This Action has been completed.

During this reporting period, CPHCS' Field Support Division (FSD) staff continues to work collaboratively with the Corrections Corporation of America (CCA) on finalizing policies and implementing monitoring tools related to the systemic issues identified in the July 2008 Remedial Plan, which came as a result of the May 2008 visit to Tallahatchie County Correctional Facility (TCCF) in Mississippi. While the initial implementation of the approved policies and monitoring reports were to be implemented at TCCF, CCA began implementing them at all five facilities currently housing California patient-inmates. Therefore, discussions related to rolling out the Remedial Plan to the remaining facilities are no longer required.

During this reporting period, the following policies were approved for implementation by CCA, CCA 13-58, Medical Records; CCA 13-70, Pharmaceuticals; CCA 9-18, Transportation Procedures; CCA 13-86, Transfer/Release Screening & Follow-up; CCA 13-34, Emergency Medical Response; CCA 13-37, First-Aid/Spill Kits; and CCA 13-74, Privacy of Protected Health Information.

[41] As CPHCS clinical leadership provides input into the pending policies, there has been a need for additional revisions and continued discussions with CCA staff to resolve the outstanding issues so that

we can finalize the remaining policies. The pending policies are CCA 13-06, Chronic Care & Disease Management; CCA 13-47, Infection Control; CCA 13-56, Credentialing, Privileging, & Licensure, and CCA 13-52, Continuous Quality Improvement, which includes policies related to peer review, mortality and morbidities, sentinel events, medical incidents and medical investigation.

Current Activities

The following provides an overview of the current activities FSD staff is involved in related to ensuring CCA compliance with the Remedial Plan developed in July 2008.

1. *CPHCS Clinical Performance Appraisals of CCA Primary Care Providers*

   In August 2008, CPHCS clinical staff began completing Clinical Performance Appraisals (CPAs) of all CCA Primary Care Providers (PCPs) providing care to California patient-inmates. The reviews are to ensure that appropriate care is being provided by the CCA staff providing medical care to our patient-inmate population. CCA has also begun the process of generating CPAs on their providers. FSD staff is working with CCA and CPCHS clinical leadership to finalize the CCA policy related to this requirement. It is anticipated that the policy will be finalized during the next reporting period. FSD staff is in the process of developing a report to track the status and outcome of this process. It is anticipated that the information will be available during the next reporting period.

2. *Weekly Physicians Collaborative Update on COCF Patient-Inmates*

   In November 2008, FSD staff initiated a weekly conference call with all CCA Physicians providing care to the California patient-inmate population, including CCA Regional Medical Directors. The purpose of these calls is to review patient-inmates with significant changes in their medical condition resulting in complex, serious and/or unstable conditions to ensure appropriate care is being provided and to determine whether or not the change in their medical condition is so significant that the patient-inmate is no longer eligible to be housed out-of-state. These calls continue to occur on a weekly basis. FSD staff is in the process of developing a report which will provide an overview of the outcomes of these calls. It is anticipated that the information will be available during the next reporting period.

3. *CPHCS Review of Credentialing Information of CCA PCP Candidates*

   In November 2008, CCA began forwarding CPHCS clinical staff copies of all required credentialing material for potential candidates for hire by CCA. Implementation of this process ensures that CCA is hiring PCPs who have the appropriate credentials based on CPHCS requirements to provide care to the California patient-inmate population. FSD staff is working with CCA and CPCHS clinical leadership to finalize the CCA policy related to this requirement. It is anticipated that the policy will be finalized during the next reporting period.

[42] 4. *Post Audits of Patient-Inmates Transferred Out-of-State*

To ensure that the appropriate patient-inmates are transferred out-of-state, Registered Nursing staff assigned to FSD began the process of conducting post audits of the Unit Health Record (UHR) for all patient-inmates transferred out-of-state. The post audit consists of reviewing the patient-inmate's UHR and the screening documents completed by field nursing staff reflecting COCF eligibility.

In instances where it is found that a patient-inmate has been inappropriately transferred out-of-state, a list containing pertinent information regarding the discrepancy is forwarded to the CMO of FSD for review and determination regarding the action to be taken (either the patient-inmate is to be returned to California or he remains at the out-of-state facility). To date, no patient-inmates have been returned as a result of this review.

5. *Establishment of Monitoring Reports*

In April 2009, staff assigned to FSD developed and implemented seven Monitoring Reports that ensure compliance with Plata policy requirements for specific systemic issues that were identified during the visit to TCCF in May 2008. The initial reports were manual and generated a significant workload increase for both CCA and FSD staff. In October 2009, FSD staff, with the assistance of Information Technology staff, began the process of automating these reports and we anticipate having executive management reports for CPHCS and CCA management by January 2010.

The reports are required to be submitted on a daily, weekly or monthly basis and are as follows:

Daily Reports (Next Day)

1. Transportation Monitoring Requirements
2. Watch List Monitoring Requirements

Weekly Reports (Due Every Tuesday)

1. Intake Screening Monitoring Requirements
2. Specialty Care Referrals Monitoring Requirements
3. Hospital Stay and Emergency Department Visits Monitoring Requirements

Monthly Reports (Due the 5th of each month)

1. Sick Call Monitoring Requirements
2. Chronic Care Monitoring Requirements

Upon receipt of these reports, Nursing Consultants within FSD review the reports for their assigned facility to ensure compliance. When discrepancies are noted, they take the appropriate steps to ensure it is clarified and/or resolved to ensure compliance with policy requirements.

[43] 6. *COCF Reception Center Transfer and Screening Process*

While it was anticipated that CPCHS and CDCR would roll-out the COCF Reception Center screening and transfer process at the remaining Reception Centers, this did not occur during this reporting period. With the scheduled implementation of the new medical classification system at the Reception Centers in January 2010, there is no longer a need to report on this issue.

7. *Clinical Staffing Levels at CCA Facilities*

   FSD and CCA staff developed a matrix to assist CPHCS clinical leadership with identifying the specific number of clinical and nursing staff providing care to the California patient-inmate population at each of the five CCA facilities. This information has been submitted to CPHCS clinical leadership for their review, modification, and/or approval of the staffing levels identified. It is anticipated that this issue will be resolved during the next reporting period.

8. *Compliance Audits Beginning January 2010*

   FSD has established an audit schedule for 2010 and 2011. Two on-site visits will be conducted of each facility by June 30, 2010. Effective July 2010, an on-site visit will be conducted at each facility a minimum of three times per year. Any significant issues that impact this schedule will be documented in future reports.

   The audits will consist of three components:

   A. Review of the roll-up of the Monthly Monitoring Reports for the three month period prior to the on-site audit.

   B. Electronic Medical Record Review, which is required to be completed at least two weeks prior to the on-site audit.

   C. On-Site Facility Audit.

Information obtained from the audit will be presented in a final report, which will be distributed to CPHCS, CDCR and CCA executive management staff. CAPS will be required to address any areas of deficiency.

Community Correctional Facilities

During the last reporting period, an update was provided regarding the seven CCF contracts that would be expiring by June 30, 2011. However, at this time, funding has not been identified to support the contract renewal process. Additionally, due to population concerns, CDCR has made a decision to move forward with closing three of the CCFs that are expiring on June 30, 2010. A 60 day notice has been served, with a closure date of December 25, 2009 (close of business).

Also during this reporting period, FSD staff conducted site audits at four CCFs. The remaining CCFs are tentatively schedule to be reviewed between January-March 2010. As reports are finalized, FSD staff will work with the facilities and CDCR to ensure Corrective Action Plans are developed to bring the impacted facilities into compliance.

[44] Goal 5. Establish Medical Support/Allied Health Infrastructure

Objective 5.1. Establish a Comprehensive, Safe and Efficient Pharmacy Program

During this reporting period, implementation of the pharmacy services Road Map to Excellence continued to move forward and show progress. The Road Map gives priority to achieving improved patient safety and health outcomes, developing an evidence-based pharmacy practice and increasing cost-efficiency. Progress during this reporting period is detailed below.

Action 5.1.1. Continue developing the drug formulary for the most commonly prescribed medications.

The CDCR Pharmacy and Therapeutics (P&T) Committee continued its monthly meetings to review utilization trends, address formulary issues, and review and approve pharmacy policies and procedures. During these meetings, the members of the P&T Committee reviewed monthly reports including the pharmacy dashboard, monthly metrics summary, the pharmacy inspection grid, a review of pharmacy cost center trends and reviewed medication error reports. After initial development work, additional review of pain guidelines was deferred by the committee to the Clinical Guidelines Committee.

During this reporting period, the P&T Committee also reviewed and discussed initiatives to address prescription duration and over-the-counter and non-pharmaceutical utilization. Clinical pharmacy support has been provided to ongoing UM initiatives.

The P&T Committee selected Ventolin HFA as the preferred formulary inhaled albuterol product. Discounted pricing for this product has been established and is now being tracked as part of the targeted contract savings. All updates to the formulary are distributed to provider and pharmacist staff, posted to the CPHCS intranet and are made available through the online Epocrates web service.

The P&T Committee has also been working collaboratively with nursing leadership to align nurse protocols with CDCR formulary. The committee approved several changes in protocol medications to eliminate any conflict with CDCR formulary. The protocols were referred to the Guidelines Committee to complete the process.

Coordination with UM was conducted to establish an appropriate level of intravenous services based on facilities' ability to compound IV admixtures in a safe manner. Solutions developed include the use of additional premix products and outsourcing depending on facility need and capability.

The Clinical Pharmacy Operations Specialists (CPOS) continued to provide in-service to facility staff on Pharmacy Policy and Procedure on a regular basis. During this reporting period, topics covered included Ch.8 - CDCR Drug Formulary, Ch. 9 - Prescription Requirements, Ch. 19 - Medications Brought into a CDCR Facility by Patients, Ch. 20 - Floor Stock Orders, Ch.25 - Inspection of Medication Storage Areas, Ch. 31 - Use of Tricyclic Antidepressants, Ch.35 - [45] Therapeutic Interchange, and Ch.38 - Prescription Turn-Around Time. In addition, CPOS discussed non-formulary approval and utilization with providers and leadership staff based on purchases and utilization data in Managed Care reports and provided in-service to facilities on the Hepatitis C medication algorithm.

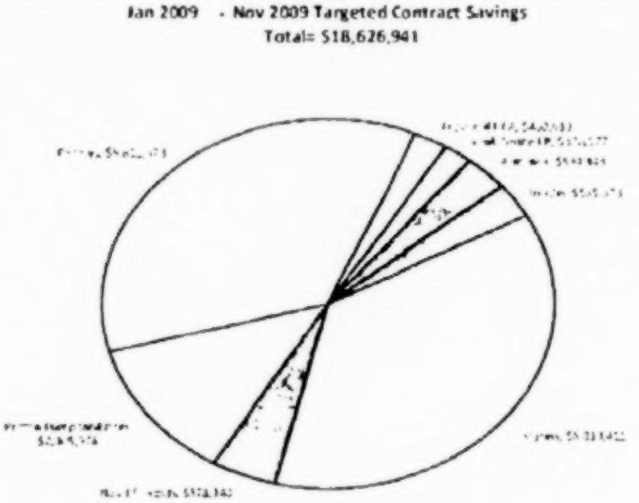
A formal Pharmacotherapy Management Consult (PMC) and process has been rolled out to several facilities, along with a pilot project to extend the duration of certain medical prescriptions to twelve months. By the end of December, CPOS will have presented PMC to Medical leadership at Central California Women's Facility, Chuckawalla Valley State Prison, Mule Creek State Prison, California State Prison, Corcoran, California Substance Abuse Treatment Facility and California State Prison, Sacramento.

Extensive emphasis continued on training and implementation of enhanced performance monitoring metrics in coordination with healthcare leadership. These activities included additional report refinement and training of staff and the Pharmacist-In-Charge

(PICs) on newly defined clinical performance metrics.A Mental Health (per member per month) cost metric was added to the Pharmacy Dashboard. Additionally, prescription related metrics relating to non-formulary prescriptions and prescriptions per inmate are being compiled on a regular basis for inclusion in the Facility Monthly Management Reports.

As displayed in Table 15, through November 2009, Maxor has documented cost avoidance of $18,626,941 thus far in calendar year 2009 from the use of targeted contracting strategies linked to P&T Committee decisions.

Table 15



[46] *Table 15 Results Explanation: These categories represent specific P&T Committee initiatives targeting particular drugs or drug classes. Savings calculated by comparing purchases using the actual targeted contract rate to the pre-targeted contract rate.*

Targeted contracts, order management activities and the implementation of a wholesaler agreement tailored specifically to address the pharmaceutical needs of the CDCR healthcare system continue to contribute to savings as displayed in Tables 16 and 17. In CY 2009, through the month of November 2009, over $44.8 million in expenditures were avoided when compared to prior historical trends.

Table 16

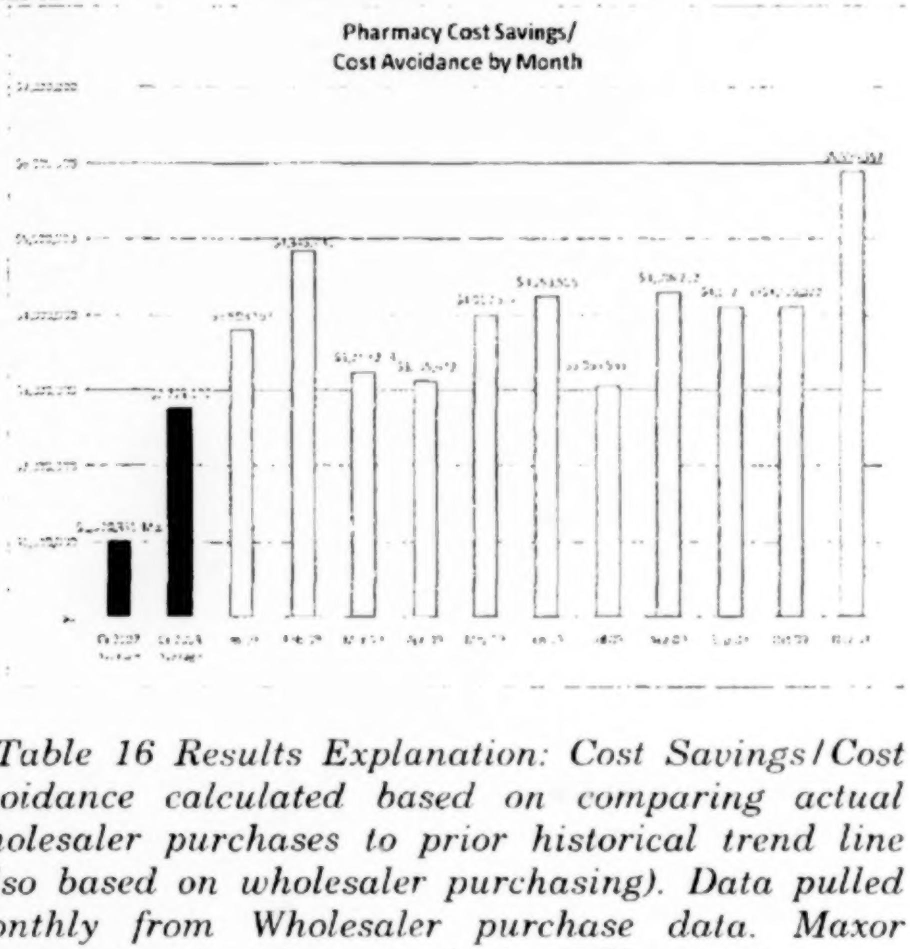


Table 16 Results Explanation: Cost Savings/Cost Avoidance calculated based on comparing actual wholesaler purchases to prior historical trend line (also based on wholesaler purchasing). Data pulled monthly from Wholesaler purchase data. Maxor began managing pharmacy in April-May 2007.

Table 17

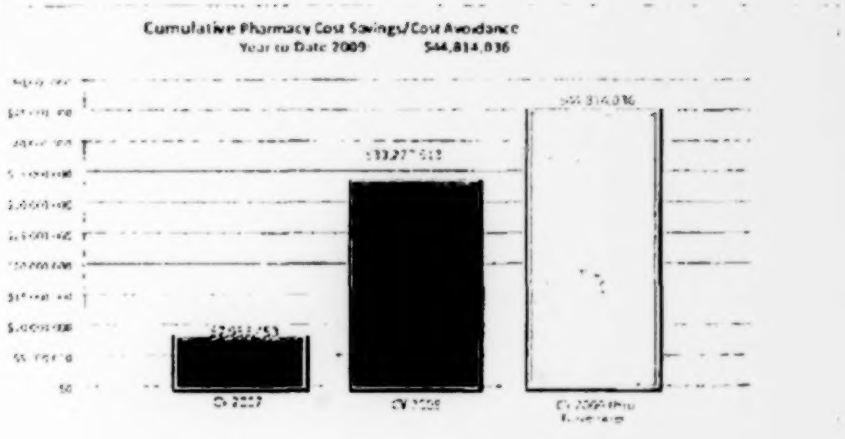


Table 17 Results Explanation: Savings/Cost Avoidance is calculated by comparing actual wholesaler purchases to prior wholesaler purchase trend line. Maxor began managing pharmacy purchasing in April-May 2007.

> *Action 5.1.2. By March 2010, improve pharmacy policies and practices at each institution and complete the roll-out of the GuardianRx® system.*

Pharmacy Policies and Practices

During this reporting period, the P&T Committee approved proposed changes to the pharmacy policies and procedures manual and completed its annual review and update of the policies. Following P&T Committee approval, the policies were sent for final review by the new policy and program evaluation department. In addition to reviewing and updating all existing pharmacy policies, two additional new policies were developed and approved. Chapter 41, Specialty Pharmaceutical Purchasing and Chapter 42, Prescription Quantity Standards were approved. A new draft policy and procedure was prepared to address quantity limits on certain groups of drugs and define packaging quantities for the planned central fill facility. This policy (Chapter 42) was approved by the P&T Committee in December 2009.

Additionally, pharmacy leadership has continued to focus on implementation of policy and procedures at the facility level to ensure compliance. To aid in this effort, a renewed emphasis was placed on the use of the *MC Strategies* online training and assessment tool to provide in-service training. Expectations were established with a targeted goal of a 95 percent completion rate. Facilities deficient in compliance are required to submit a written plan of action to bring training compliance up to the targeted levels. Also during this reporting period, two revised *MC Strategies* lessons were deployed and two new lessons (Ch. 19 - Medications Brought into a CDCR Facility by Patients and Ch. 20 - Floor Stock Orders) were released to PIC and pharmacy staff. The MC Strategies completion rate system-wide is now at 89 percent. Compliance continues to be evaluated quarterly.

[48] Recruitment efforts continue in an effort to fill pharmacy positions across the State. Work continues through the centralized hiring process to identify, interview and select qualified applicants. Also during this time period, pharmacy leadership have worked with finance and human resources staff to address significant differences between the deficient historical pharmacy staffing levels approved in prior appropriations cycles and the actual staffing levels required by current workloads and processes. While implementation of the Central Fill Pharmacy (CFP) will help in bridging this gap, discussion continues in order to ensure that mission critical services will be maintained in the interim and during the imple-

mentation of the CFP. Meetings with CPHCS leadership and finance staff are ongoing to address these issues.

Pharmacy inspections are conducted and documented monthly. The number of pharmacies with an inspection rating score of pass/problem (not failed) has increased from 21 percent in March 2007 to 64 percent in November 2009. This percentage is down from a high of 85 percent reported in July 2009. Pharmacy inspection scores are dropping largely due to late submissions of inspection reports by facilities. CPHCS is taking action to improve the timeliness of these submissions to avoid this drop in scores. Pharmacy inspection status data is displayed in Table 18.

Table 18

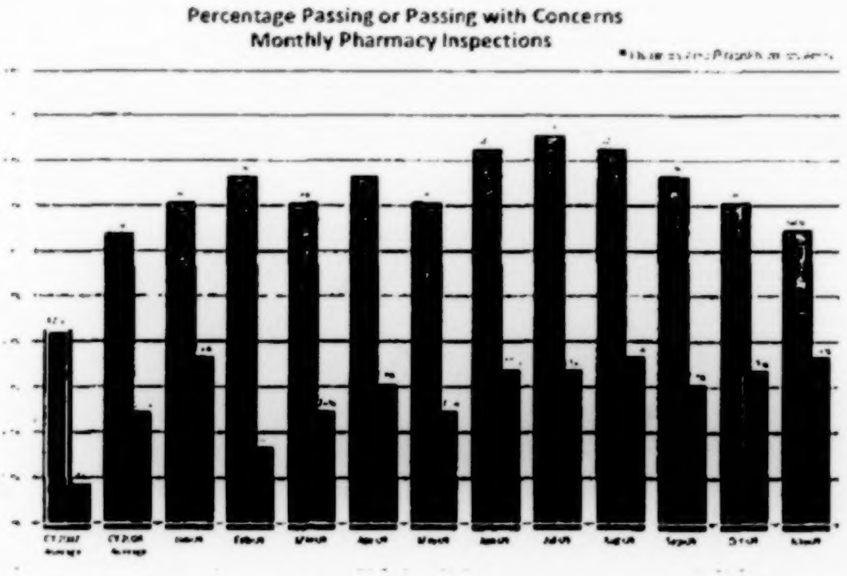


Table 18 Results Explanation Pharmacy areas are denoted in blue, and non-pharmacy locations (medication administration locations) are denoted in red: Independent Maxor Validation of Monthly Inspection Data began in February 2008.

[49] *Roll-out of the GuardianRx® System*

The GuardianRx® pharmacy operating system has now been successfully implemented in 29 of the 33 CDCR institutions. Pre-conversion meetings and training at upcoming facilities continue. The remaining four facilities are Sierra Conservation Center, Richard J. Donovan Correctional Facility, California State Prison, Solano, and California Medical Facility. Each of these facilities has significant infrastructure issues which are being considered as final scheduling takes place by the GuardianRx® Steering Committee.

The Receiver has completed initial efforts to improve pharmacy policies and practices at each institution by the initial target date of June 2009, having completed a comprehensive initial review and revision of all pharmacy policies and procedures. Efforts to enhance training and improve compliance with these policies and procedures continue. However, the timeline for rollout of the GuardianRx® system has been extended, as described above, and will not be fully implemented statewide until at least March 2010.

> *Action 5.1.3. By May 2010, establish a central-fill pharmacy.*

Work continues towards the establishment of a CFP Facility for the CDCR. The pre-centralization ambulatory model is being defined and implemented as processes are standardized and validated as part of the GuardianRx® implementation work plan. Following the final approval of the lease terms with the property owner by Department of General Services in early August, demolition, permitting and renovation work on the facility was started. Coordination with DGS architects and space planners, the CPHCS Project Manager, the construction team and the automation vendor occurs on a daily basis as this vital project enters the active construction phase. The building contractor is proceeding on schedule with the renovations and build-out of the facility. Meetings with Cornerstone Automation Systems (the vendor selected to provide the automation equipment for the facility) continue to ensure equipment specifications are met and installation schedules are coordinated. Cornerstone Automation Systems has recently advised scheduling obstacles with a potential delay of 60 days. CPHCS staff is actively working with the vendor to resolve for on time delivery.

Additionally, work related to the staffing and operation of the facility has also continued. Meetings have been held to plan the process of moving positions for the CFP and reevaluate time lines and system wide pharmacy staffing. Work is being done to define the pharmacy staffing model going forward and the interim staffing model until the CFP is fully operational. Based on current schedules, the CFP Facility is now estimated to be operational by May 2010. Once opened, it is expected to take approximately 14-18 months to transition all prisons completely over to central fill.

The Monthly Summary Reports for the months of September, October, and November are attached as Appendix 6.

Objective 5.2. Establish Standardized Health Records Practice

Implementation of the Health Information Management (HIM)/Health Records remediation road map continues to move forward to achieve improved patient health records management based [50] on evidence-based practices and increased cost-efficiency. Progress continues and is detailed below.

> *Action 5.2.1. By November 2009, create a roadmap for achieving an effective management system that ensures standardized health records practice in all institutions.*

The Receiver has been developing a plan for an enterprise-wide UHR Conversion initiative where all UHR's and loose filing at the institutions will be scanned into a 'paper-like" scanned UHR (s-UHR). This same effort will also scan all of the Paroled UHR's at the Health Records Center (HRC). This effort is taking advantage of the Strategic Offender Management System (SOMS) Custody File (C-File) scanning effort for CDCR after they have completed scanning the C-Files at each institution. The first institutions and HRC will have their UHR's scanned in July 2010 and the last institution will be completed approximately 12 months later.

The process of establishing an s-UHR will also establish a "day-forward" scanning operation at each facility that will process all loose filing. These efforts are an important step for CPHCS to advance to an electronic UHR or EMR by moving UHR users away from a paper UHR. This effort will also improve the standardization and use of healthcare forms as well as the many business processes that utilize or provide input to the UHR.

These efforts will improve the availability of the UHR at the point of care and will significantly advance the quality of new UHR content. These efforts combined with additional advancements of the CPHCS CDR and other Allied Health Services domains (e.g., Lab, Radiology, and Pharmacy) will support an effective Electronic Medical Record (EMR). The EMR provides an effective management system for ensuring standardized health records use and practice at all institutions.

At HRC there is currently a loose filing backlog of 50,000 inches. This backlog will be eliminated by a scanning process that will start by early February 2010. These scanned loose files will then be distributed to active UHR's at institutions and will no longer be missing from clinical visibility.

Active recruitment is underway for two Health Information Management (HIM) CEA positions for a Chief of Health Information Management and an Assistant Chief/Privacy Officer. These critical managers will provide CPHCS leadership guidance over stabilization, remediation and ongoing enterprise-wide HIM operations.

The Dental effort toward a more efficient organization of the Dental portion of the unit health record has been proceeding. A purchase order for 51,314 multi-tab inserts and x-ray envelopes for the dental section has been completed. Prison Industry Authority (PIA) will manufacture the items and is in the process of procuring the materials to do such. Based upon the PIA factory schedule, the Receiver estimates that the items will be distributed to the institutions in March 2010.

[51] *Objective 5.3.* Establish Effective Imaging/ Radiology and Laboratory Services

> *Action 5.3.1. By August 2008, decide upon strategy to improve medical records, radiology and laboratory services after receiving recommendations from consultants.*

Medical Records

The strategy and plan related to Health Records is addressed under Objective 5.2.

Imaging / Radiology Services

This Action has been completed.

During this reporting period, Ascendian Healthcare Consulting (formerly McKenzie Stephenson, Inc.) completed site visits to all 33 adult institutions, with the goal of improving several areas of imaging departmental functions. Standardized and accurate processes are valuable in preventing delays in diagnosing patient-inmate conditions, reducing costly repeat diagnostic studies, and improving overall safety.

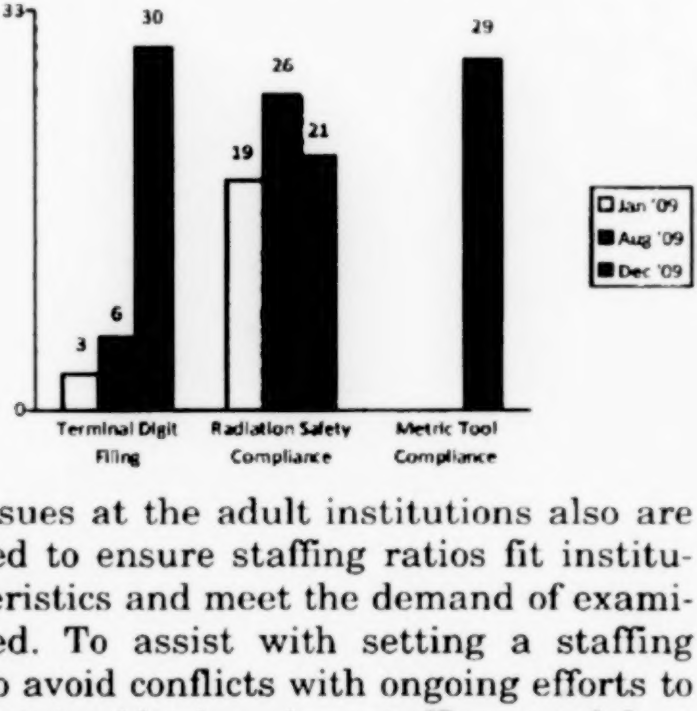
One area of focus included compliance with report and film handling, proper film filing methods, and tracking mechanisms required to safely transport medical data throughout the State. We have made significant improvements in terminal digit filing for film storage, with the number of sites in compliance rising from 6 to 30 as indicated in Table 19.

Another area of focus was to implement metrics tools designed to provide a baseline for operational volumes, workload, equipment maintenance and uptime, referrals, and other important data related to improving patient care and access. This metrics management process began in September 2009 and has been widely adopted. As shown in Table 19, 29 institutions currently report operational, clinical, and safety metrics on an ongoing basis.

A third area of focus has been compliance with radiation safety guidelines. As in Table 19, there appears to be a negative trend in radiation safety compliance since August. This is a result of a new and stricter compliance measurement and monitoring regime, which includes new metrics associated with Physicist reports and Radiation Supervisor positions. We are working with all non-compliant sites to ensure that the proper paperwork is submitted and supervision is provided as required.

[52]

Table 19: Imaging/Radiology Metrics - Compliance by Institution



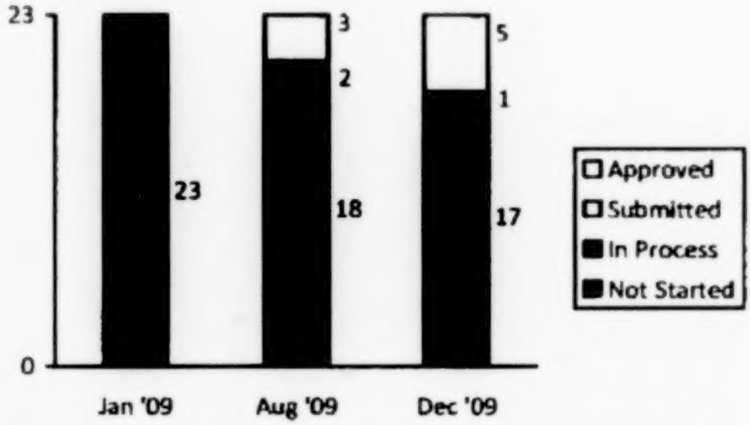
Personnel issues at the adult institutions also are being addressed to ensure staffing ratios fit institutional characteristics and meet the demand of examinations ordered. To assist with setting a staffing baseline and to avoid conflicts with ongoing efforts to redesign the statewide imaging staffing model, a hiring freeze within Radiology was implemented. This hiring freeze was coordinated with CPHCS Human Resources and Regional Personnel Directors. A revised staffing model is under review, with approval and implementation expected for early 2010.

Ascendian Healthcare Consulting expects to complete Mammography Quality Standards Act (MQSA) certification at Valley State Prison for Women prior to the end of 2009. Issues related to equipment reliability and documentation initially delayed the completion of this process, however the paperwork has since been filed. In addition, all three female institutions are prepared to comply with recent state legislation that reinforces existing policies regarding the posting of violations of MQSA guidelines.

Our team continues to work through the 23 different types of contracts held for support of Radiology and Imaging Services. As indicated in Table 20, we have been making progress on the remediation of these contracts. Due to concerns related to contract accuracy and accountability, the scope of the work conducted by this team now includes management and oversight of vendor invoicing and payment.

[53]

Table 20: Progress of Radiology/Imaging Contract Remediation



Work on the Mobile MRI program has ceased due to project budget and scope changes. CPHCS has established a preference for contracted services as a long-term solution to providing on-site MRI services, whereas the previous strategy was to implement state-owned and operated MRI services. We currently are reviewing the infrastructure at all institutions to determine what improvements are required to meet the minimum requirements for mobile MRI and CT service. The first five sites selected (California State Prison, Corcoran, California Substance Abuse Treatment Facility, North Kern State Prison, Kern Valley State Prison and Wasco State Prison) all require upgrades to provide level concrete pads or proper electrical hookups. While we had initially planned to expedite this project, CPHCS learned that the project is subject to Section 6 state funding requirements and approval process. To fulfill this process, the timeline has been adjusted and is expected to be completed by end of fiscal year 09/10.

We continue to coordinate with other CDCR and CPHCS project teams that are implementing technologies overlapping with imaging services (e.g., transcription, scheduling, CDR). Our goal is to ensure that these overlapping processes accommodate the work and data flow required for interoperability with Radiology and Imaging Services. However, recent changes in budget and resource allocation have delayed the Radiology Information System (RIS) implementation, which is designed to capture relevant patient data and allow for interoperability across the enterprise. Revised expectations on RIS implementation schedule, cost, and patient care impact currently are under development.

Laboratory Services

The Receiver has completed a work plan to stabilize/reform the Reference Lab Contracts and to provide a statewide reference lab service. Approximately half of CPHCS lab tests are performed through the CPHCS Reference Lab contracts. This statewide service will significantly improve the quality, timeliness, and effectiveness of reportable lab results that inform clinical decisions at [54] each of our institutions. The next two reporting periods will be focused on implementing this work plan.

The Receiver has begun the recruitment for a Chief of Laboratory Services. By June 2010, Laboratory Services leadership will be recruited to implement a State managed sustainable Laboratory Services program.

Objective 5.4. Establish Clinical Information Systems

> *Action 5.4.1. By September 2009, establish a clinical data repository available to all institutions as the foundation for all other health information technology systems.*

The goal of the CDR project is to store key patient health information, such as current medications, allergies, lab results, healthcare encounters, problems, etc., in a standardized manner and ensure availability of this information to providers at the point-of-care to support clinical decision-making. The current phase of the CDR is focused on providing current medications, allergies, and reference lab results.

As of December 2009, the CDR has transitioned into the Maintenance & Operations Phase, with rollout of the CDR to Valley State Prison for Women; California Correctional Facility for Woman and Los Angeles County institutions. In the months leading up to December, historical data was loaded from custody, pharmacy and laboratory partners and live data feeds from these partners was initiated. Staff at the pilot institutions was trained on the CDR and on-site and remote assistance was provided to support the roll out.

The pilot phase of the project will run through January 2010. During this period the system will be evaluated for stability and performance. Remediation work will be performed in areas that require such services. Rollout to additional institutions will begin in February 2010.

Objective 5.5. Expand and Improve Telemedicine Capabilities

> *Action 5.5.1. By September 2008, secure strong leadership for the telemedicine program to expand the use of telemedicine and upgrade CDCR's telemedicine technology infrastructure.*

This Action has been completed.

Telemedicine staffing and governance continues to improve. During this reporting period, CPHCS hired 2 new staff members to conduct the scheduling of specialty services, and are recruiting for a Health Program Manager. We also held the initial meeting of the Telemedicine Services Core Leadership Team.

Progress in expanding telemedicine system-wide is shown in Table 21. While total RFS volume is declining because of the recently implemented utilization management program, telemedicine encounters are continuing at a steady pace.

* * * *

[55] Phases One and Two of the six-institution initiative to expand telemedicine services are underway (Table 22). This initiative is being conducted at North Kern State Prison, Kern Valley State Prison, Richard J. Donovan Correctional Facility, Centinela State Prison, California State Prison at Corcoran and Substance Abuse Treatment Facility. At the six institutions, we are expanding

telemedicine equipment, addressing access to care obstacles, expanding the provider network, increasing the number of telemedicine specialties, and taking other steps to increase telemedicine usage. We also are collecting statistics to measure our progress in increasing telemedicine encounters while at the same time reducing off-site specialty services encounters. This data will be shared in future reports.

* * * *

[56] The CPHCS team is working closely with our Information Technology experts to identify the most cost-effective approach to developing and expanding the technology infrastructure that supports the delivery of telemedicine services. We recently met with several vendors to review current technologies and equipment as it relates to telemedicine services, including *store and forward* technology.

During this reporting period, CPHCS has implemented various process and staffing improvements. These improvements include reassigning the RN staff from scheduling and administrative functions to clinically focused tasks of the Telemedicine Program. We also are in the process of automating our telemedicine scheduling process.

The "Provider On-Boarding" process was fully implemented in this reporting period to expand patient access to telemedicine specialty providers, with an additional provider organization "on-boarded" to provide statewide services. The addition of the new providers has increased the number of specialty services offered from sixteen to twenty. These additional services are Plastic/Reconstructive, Nephrology, Oncology and Urology. We are also working to transition the UCSF on-site services to telemedicine.

Ongoing review of statewide scheduling backlogs and patient needs will continue to be a factor in provider recruitment efforts, which will help us meet demand for specialty care statewide. The CPHCS team is engaged in discussions with prospective medical groups and providers throughout the state that can provide telemedicine services. To support this expansion, we have updated the contract language to include telemedicine provisions in all medical general services agreements. The Telemedicine Program also is working with our Credentialing and Privileging unit to establish credentialing protocol for telemedicine providers.

During the next reporting period, we expect to successfully complete the six-institution initiative, complete the automation and re-engineering of our scheduling function, further expand our provider network and launch initiatives to increase telemedicine at other institutions. CPHCS anticipates the successful completion of the six-institution initiative and a phased rollout of increased telemedicine services statewide.

[57] Goal 6. Provide for Necessary Clinical, Administrative and Housing Facilities

Objective 6.1. Upgrade administrative and clinical facilities at each of CDCR's 33 prison locations to provide patient-inmates with appropriate access to care.

Progress on this objective continues to be impacted due to lack of funding. Assessments, planning, design and construction progress was limited due to the funding impacts. The timeframes originally established in the action items are no longer feasible and will continue to be negatively impacted until such time as AB 900 funding becomes available.

> *Action 6.1.1. By January 2010, completed assessment and planning for upgraded administrative and clinical facilities at each of CDCR's 33 institutions.*

In concert with the most recent Abt study data and the proposed medical classification system proposed by CPHCS's medical planning group, Vanir is providing input to this team from the data collected during site visits at all 33 institutions. This input includes confirmation of existing conditions, such as confirming bed counts and locations at each yard, and identifying the best potential locations for needed new beds identified by the medical planning group as having an acute care mission.

> *Action 6.1.2. By January 2012, complete construction of upgraded administrative and clinical facilities at each of CDCR's 33 institutions.*

Upgrade Construction at Avenal State Prison:

Construction at Avenal State Prison is in its final stages. Work under construction includes three yard clinics to provide medical and mental health treatment space, an Administrative-Segregation clinic and a healthcare administration building to provide support for healthcare access and administration, on schedule for completion by January 2010. Institution staff began moving into the new buildings sequentially, starting in December 2009.

Work on hold due to funding limitations includes the following: expansion of medical records, conversion and expansion of the pill room, new inmate waiting building, canopies at pill lines and waiting areas. Construction of a new medical warehouse has been cancelled. Once the funding for the Upgrade Program has been identified, there will be a statewide master planning effort that will address the need to complete those construction projects currently on hold.

Objective 6.2. Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs.

The "Receiver's Report on Options for Long-Term Care Bed Construction," filed with the court on February 6, 2009, details the four-year history of the Receivership's efforts to work with CDCR and the State to secure funding for construction of facilities which are a necessary step toward bringing prison healthcare up to constitutional standards. A complete copy of that report is available on the website http://cprinc.org/docs/court/doc2065_20090206_Options.pdf.

[58] The construction options identified in that report were intended to be one component of a long range plan to bring medical care up to constitutional standards. The other components are dependent upon improvements in prison and health care, and program improvements that have not been fully realized in part because of CDCR's severe.

In brief summary, the initial planning efforts, begun in 2006, culminated in 2008 with an agreement with the Administration to seek new funding in the amount of $6 billion to construct seven new facilities around the state which would have added approximately 10,000 beds for inmates requiring basic care for long-term, chronic medical problems, serious mental health concerns, and medical conditions requiring special housing and ready access to care. The plan was intended to satisfy healthcare bed needs projected out to 2018. Under the Receiver's plan, these facilities would have been built and operated by the Receivership to ensure timely completion of construction and operation of the facilities consistent with constitutional standards. The Administration also agreed to $1 billion in funding to improve facilities at existing prisons to support medical and mental health treatment (this figure was raised during 2008 to $2 billion when the Administration requested that the Receivership take on facilities improvements for the dental program). The Receiver believes that this $8 billion capital investment, if combined with other operational and staffing improvements and a reduction in the prison population, would likely be sufficient to end the four primary class actions involving prison health care in the near future.

Beginning in July of 2008, the Administration withdrew its support for this investment. After a brief period of litigation between state officials and the Receivership (which is still pending before the Ninth Circuit), and with the collapse of the national economy and California's budget, the Receiver began working collaboratively with Secretary Matt Cate and other CDCR staff to attempt to scale back construction plans to a level more consistent with available resources. These discussions ultimately resulted in CDCR submitting a long-term bed plan to the *Coleman* court which provides approximately $2.34 billion in funding for healthcare-related construction to be financed from the sale of bonds previously authorized by AB 900. Instead of 7 facilities and 10,000 new beds to be operated by the Receivership, the new plan envisions only 1 new facility of approximately 1,600 beds for inmates with medical and mental health problems, the use of three juvenile justice facilities which would be converted to hold approximately 3,200 inmates with medical and mental health conditions, and allocation of $700 million for improvements to existing facilities. Although the current plan is likely to fall short of actual needs in some material respects, the Receiver believes it is the most that can be accomplished at this time given the state's serious financial problems and the amount of funding available under AB 900.

As of this date, although there is a plan to build, the state still has not provided access to any funding to implement this plan, it remains uncertain whether funding will ever be made available for these purposes, and it is unclear whether the State will significantly reduce its prison population.

> [59] *Action 6.2.1 Complete pre planning activities on all sites as quickly as possible.*

During this reporting period, planning activities for the CCC have continued along with planning models and assumptions for the converted DJJ facilities. The CCC facility prototype, operational plans, facility plans, staffing model, and integrated healthcare program model are being revised and completed to a draft level that will allow for the facility to be constructed within an accelerated time-frame.

In November 2009, CPHCS construction staff transitioned to CDCR Facility Planning, Construction and Management Division to combine the construction efforts on all AB 900 projects.

> *Action 6.2.2 By February 2009, begin construction at first site:*

This action has been delayed until such time as AB 900 funding becomes available.

Stockton Site Environmental Impact Report (EIR) Status - On October 12, 2009, the Receiver certified the final EIR and also signed the Resolution of Approval, approving the proposed project and the Secretary of the CDCR concurred. The Notice of Determination was filed on October 19, 2009.

A petition for writ of mandate challenging the EIR entitled *Greater Stockton Chamber of Commerce, County of San Joaquin and City of Stockton v. J Clark Kelso, in his capacity as Receiver and the Department of Corrections and Rehabilitation* was filed on November 17, 2009 in San Joaquin Superior Court, Case Number 39-2009-00230310 CU-WM-STK. An amended petition was filed on November 19, 2009. Both the Receiver and the CDCR were served on November 24, 2009. The case was removed to the jurisdiction of the United States Federal Court for the Eastern District of California on November 25, 2009. Notices of Related Case were filed on December 3, 2009 and the court ordered the matter related to the *Coleman v. Schwarzenegger* Case No.2:90-cv-520 LKK on December 4, 2009, with a status conference set for February 16, 2010. The attorneys for both the Receiver and CDCR are reviewing the amended petition and are preparing the record and necessary responses. The attorneys for both the Receiver and CDCR filed answers to the amended petition and are preparing the administrative record for certification by January 25, 2010. Petitioners filed a Motion to Remand the case back to state court, which is set for hearing before Honorable Judge Karlton on January 25, 2010.

Action 6.2.3 By July 2013, complete execution of phased construction program.

A phased construction schedule has been developed that provides for an accelerated schedule to open these beds by April of 2013.

[60] *Objective 6.3.* Complete Construction at San Quentin State Prison

Action 6.3.1. By December 2008, complete all construction except for the Central Health Services Facility.

With the exception of small closeout "punch list" items, construction is complete. All projects are complete and the areas are occupied by staff and inmates as appropriate, including: the medical warehouse; east and west rotunda clinics; personnel offices; triage and treatment area; clinic heat project; and replacement parking spaces. Exercise yards have been relocated and office modular buildings have been added.

Action 6.3.2. By April 2010, complete construction of the Central Health Services Facility.

The Central Health Services Building achieved substantial completion on November 19, 2009, almost three months ahead of the required contract completion date of February 8, 2010. Staff began occupancy of the building and the clinics and started treatment of inmates in December 2009. We are targeting a complete move of all mental health and medical patients by end of January 2010.

[61] Section 4
Additional Successes Achieved by the Receiver

A. Joint Governing Body for Integrated Care

In a health care organization the Governing Body is the highest policy making body for the provision of health care. Consistent with community standards and health care organizations, the CPHCS and DCHCS Governing Body are responsible for the administration, direction, monitoring, and quality of health care services provided to inmate-patients within the adult institutions. These Governing Body Committees take final action on recommendations from the Professional Practice Executive Committee regarding all practitioners within CDCR.

During this reporting period the two separate and distinct Governing Bodies,

1) Medical—responsible for the practice of physicians, nurse practitioner's and physician assistants and 2) Mental Health and Dental - responsible for the practice of psychiatrists, psychologists, licensed clinical social workers, and dentists, were merged in to one Governing Body. This is a critical step in a deliberative process to reintegrate the health care services within CDCR.

To facilitate a seamless transition of enterprise wide health care policies and processes, the newly reconstituted Governing Body will focus on interdisciplinary practices issues and resolutions. The new Governing Body began convening in October and will draft formal Bylaws within the upcoming months.

B. Health Care Master Bed Plan — *2009 Chronic and Long-term Care in California Prisons: Needs Assessment Projections*

Guided by the Vision and Mission of the Receiver's Turnaround Plan of Action, CPHCS is committed to ensuring a sustainable medical care system that increases the effectiveness of medical care while implementing system efficiencies for cost containment and savings. In support of that effort, the Receiver directed an assessment of the long-term care prison medical beds to ensure that the capacity was sufficient to support a constitutionally adequate level of medical care for inmates. Abt Associates revised their *2007 Chronic and Long-term Care in California Prisons: Needs Assessment* projections and improved the study outcome by adjusting the data collection tool. Pursuant to concerns raised about the 2007 study by independent reviewers, the assessment tool was modified and updated under the direct leadership and participation of CHPCS clinical staff. Complete analysis of the *Abt 2009 Chronic and Long-term Care* study is undergoing final review and will be shared in the 1st quarter of 2010.

To ensure resolute handling of this critical project, the Receiver directed a Medical Master Bed Planning Executive Leadership Group be created to oversee the medical bed master planning effort utilizing data from the study. In addition, a Health-Care Bed Master Planning Workgroup (Workgroup) was formed. The groups are comprised of representatives of all stakeholders, [62] including Court representatives for Plata, Coleman, Armstrong, and Perez, as well as leaders representing CPHCS, the CDCR Mental Health and Dental Programs, Facilities, the Division of Adult Institutions, and the Department of Mental Health.

With the benchmarking data from the study, the Receiver's goal is to create an Integrated Health Care Master Bed plan that will provide a continuum of care and serve a variety of care levels (including medical, mental health, and dental), that will meet or exceed the bed and treatment needs for integrated health care services, and that fulfills custody requirements for safety and security of CDCR facilities. The plan will incorporate the results of the following: population specific health care studies; data/findings from medical and mental health classification systems; the Mental Health Long Term Bed Plan filed with the Coleman Court; and the Dental Services Plan.

The Workgroup is nearing completion of its analysis and will provide recommendations for an Integrated Health Care Master Plan. They will present the recommendations in late January to the Leadership Group and Court monitors. It is anticipated that these recommendations will include adjustments to the current Bed Plan which are necessary to meet the projected long term health care needs of California's inmate-patients while ensuring the best use of planned construction resources.

[63] Section 5

Particular Problems Faced by the Receiver, Including Any Specific Obstacles Presented by Institutions or Individuals

While the Receivership continues to make progress in many key areas to achieve the goal of providing a constitutional level of healthcare within California's adult correctional system, the State's fiscal crisis and resulting employee furlough program has had an impact administratively and at the Institutions, as it has on many state government operations. While this impact is difficult to define and measure, this Tri-Annual Report identified programmatic areas in which timelines have been adjusted. Many staff intensive administrative functions, such as inmate appeals processing and invoice processing, have failed to meet their goals. While blame for these failures can not be placed solely on furloughs or the lack of funding for new positions, there is little doubt that budget cuts and furloughs are contributing factors to some of these setbacks.

The budget forecast coupled with California's low financial rating will present challenges for all in 2010 and the years that follow. However, the Receiver continues to utilize all available resources to ensure that the goals and objectives within the Turnaround Plan of Action are achieved and will continue strive in these efforts to fulfill the Vision and Mission.

[64] Section 6

An Accounting of Expenditures for the Reporting Period

A. *Expenses*

The total net operating and capital expenses of the Office of the Receiver for four months ended December 31, 2009 were $3,033,872 and $6,873,314 respectively. A balance sheet and statement of activity and brief discussion and analysis is attached as Appendix 7.

B. *Revenues*

During the four month period ending December 31, 2009, the receiver requested transfers totaling $1,100,000 from the state to the California Prison Health Care Receivership Corporation (CPR) to replenish the operating fund of the office of the Receiver for the reporting period 2009-2010 Fiscal Year.

All funds were received in a timely manner.

[65] Section 7

Other Matters Deemed Appropriate for Judicial Review

- Coordination with Other Lawsuits

During the reporting period, regular meetings between the Receiver and the monitors of the Coleman, *Perez*, and *Armstrong* ("Coordination Group") class actions have continued. Coordination Group meetings were held on September 22, 2009, November 17, 2009, and December 9, 2009. Progress has continued during this reporting period.

- Master Contract Waiver Reporting

On June 4, 2007, the court approved the Receiver's Application for a more streamlined, substitute contracting process in lieu of State laws that normally govern State contracts. The substitute contracting process applies to specified project areas identified in the June 4, 2007 Order and, in addition, to those project areas identified in supplemental orders issued since that date. The approved projects areas, the substitute bidding procedures and the Receiver's corresponding reporting obligations are summarized in the Receiver's Seventh Quarterly Report and are fully articulated in the court's orders, and therefore, the Receiver will not reiterate those details here.

During the last reporting period, the Receiver has used the substitute contracting process for various solicitations relating to services to assist the Office of the Receiver in the development and delivery of constitutional care within CDCR and its prisons. However, those solicitations have not yet resulted in fully executed and approved contracts. Therefore, those contracts will be reported in subsequent Reports to the Court.

[66] Section 8
Conclusion

We are approaching the halfway point in implementing the Turnaround Plan of Action. As this report reveals, there are many accomplishments which have contributed to improving the quality of care and reducing avoidable morbidity and mortality. At the same time, however, it is worth remembering that we have embarked on this extraordinarily challenging organizational improvement initiative in the midst of what is the worst budget and organizational conditions in California government in half a century.

Overcrowding continues essentially unabated, resources to improve and expand facilities have not been made available, employees have been subjected to furloughs and other employment pressures which undoubtedly interfere with their productivity, and the State's cash condition is unstable.

While we have clearly been presented with all of these challenges, as a State and the Receivership, we continue to work collaboratively with CDCR, the Department of Finance, the Department of Personnel Administration and the Governor's Office to achieve as much alignment as possible. The pace of our further progress will depend to a great extent upon our ability to build on the collaborative trust that we have developed over the last year and to gain the support from the State that we need to complete our task.

Achieving a
Constitutional Level of Medical Care In California's Prisons

Fourteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action

[Filed: 05/27/10]

May 15, 2010

* * *

[5] Section 1
Executive Summary

In our first Tri-Annual reporting for 2010, we recognize and share the accomplishments achieved by prison healthcare stakeholders and advocates. While we continue to be faced with unprecedented budget challenges and managing a diverse stakeholder process system, progress has continued toward attaining the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- Prison Healthcare Chief Executive Officer (CEO)—Since the CEO examination was launched on December 24, 2008, 476 CEO applicants have been added to the certification list and 12 hires have been completed. The pool of CEO candidates is very competitive and interest remains high with 12 CEO positions to fill for oversight of 33 institutions.
- Utilization Management (UM)—We recently hired a Lead UM Nurse Consultant who has successfully recruited 5 UM Nurse Consultant Program Review (NCPR) nurses who

have been trained to support field based regional UM and care coordination activities. They are all actively working in the 4 Regions, to align the Receiver's UM objectives and institutional outcomes.

- The Request for Proposal (RFP) to obtain a medical services network from a Preferred Provider Organization (PPO), as allowed under the new legislation (SB X4 13, 2009, which amended Penal Code section 5023.5), was released October 20, 2009. Proposals were received and are in evaluation. Due to the number and complexity of proposals received, the evaluation period has been extended into the next reporting period. The plan is to make an award by the first of July 2010.

- Medical invoice processing activity has continued to be streamlined for efficiency through the use of Third Party Administrators (TPA) and system enhancements. As of March 2010, the TPA is within the mandated 30-day processing timeframe. The Two-Year Post Audit identified billing discrepancies which has resulted in $13.8 million in refunds as of early April 2010. These refunds apply to the timeframe between July, 1, 2007 and June 30, 2009 and will not apply to current year savings.

- Pharmacy—On April 15, 2010 the Office of the Inspector General (OIG) released their report entitled "Lost Opportunities for Savings within the California Prison Pharmacies." While acknowledging that there is more to do to rein in the high cost of inmate medicines, the report was a snapshot of a changing situation in our pharmacies. Our Tri-Annual and Monthly reports continue to showcase the progress made in pharmacy and the cost savings/avoidance achieved through the implementation of formulary management, over-the-counter (OTC) policy changes, the return-to-stock program, and the rollout of the Central Fill Pharmacy Facility (scheduled to open in May) and program.

- Telemedicine: Phase 2 of the Telemedicine Services Project was completed, which included the Six Institution Initiative to Expand Telemedicine Encounters. The Initiative resulted in a 14 percent increase in telemedicine services at the target institutions, and provided [6] experience that will facilitate telemedicine expansion at the other California Department of Corrections and Rehabilitation (CDCR) institutions.
- Avenal—Construction at Avenal State Prison is complete. All clinics were fully operational as of February 5, 2010.
- San Quentin—The Central Health Services Building is complete. We began seeing inmates in December 2009. CTC licensure was achieved in January 2010.
- California Health Care Facility (CHCF)—In January 2010, the Department of Finance submitted the 30-day notification letter to the Joint Legislative Budget Committee (JLBC) for review. At the request of the JLBC this project was pulled from the February Public Works Board (PWB) agenda and has not been rescheduled. Legislation (AB 552) is pending

that would clarify the use of AB 900 bond funding for this project.

While we continue to make strides in many important areas that bring us closer to the goal of providing a constitutional level of healthcare within California's correctional system, the momentum of these efforts continues to be affected by the State's budget and fiscal crisis. The budget and fiscal crisis is likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core healthcare areas. However, productivity has been impacted throughout the organization, and coupled with some staff turnover, certain projects and initiatives have been delayed in their implementation. Due to these factors, this report will reflect extensions on some of the objectives and action item dates to fulfill the goals.

Moreover, although the Administration has made some proposals to the Legislature to reduce prison population and overcrowding (in part to address the state's budget crisis), so far, those proposals have not been fully embraced by the Legislature and none of them has yet been implemented. CDCR's prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care.

Format of the Report

To assist the reader, this Report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated

Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the California Prison Health Care Services (CPHCS) website (http://www.cprinc.org/receiver_mo.aspx).

2. *Appendices*: In addition to providing metrics, this report also references a number of documents that are provided to the reader in the included Appendices filed concurrently with this report.

* * *

[9] Section 3

Status of the Receiver's Turnaround Plan Initiatives

Goal 1. Ensure Timely Access to Health Care Services

Objective 1.1. Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release

Action 1.1.1. By January 2009, develop standardized reception screening processes and begin pilot implementation

This action has been completed.

Action 1.1.2. By January 2010, implement new processes at each of the major reception center prisons

The Reception Center redesign is planned to occur after completion of Action 1.1.3 in January 2010. Re-evaluation of the reception center processes, established in Action 1.1.1, and statewide implementation of the new processes at each of the major reception centers is expected by January 2011.

Action 1.1.3. By January 2010, begin using the new medical classification system at each reception center prison.

This action has been completed.

On January 20, 2010, all Reception Center institutions began using the Medical Classification System on all newly arrived inmates. During this reporting period, Local Operating Procedures for each institution were approved by the Regional Leadership Teams and the Medical Classification Chrono was implemented. At the time of this report nine of eleven Reception Center institutions have self-certified they are compliant with the Medical Classification System Policy and Procedure. The Regional Leadership Teams are currently preparing for the formal site certification visits.

Action 1.1.4. By January 2011, complete statewide implementation of the medical classification system throughout CDCR institutions.

On March 8, 2010, all non-reception center institutions began implementation of the Medical Classification System. As the institutions report self-certification status, the Regional Leadership Teams will schedule formal site certification visits. Implementation certification of the Medical Classification for all institutions is expected before January 2011.

Objective 1.2. Establish Staffing and Processes for Ensuring Health Care Access at Each Institution

Action 1.2.1. By January 2009, the Receiver will have concluded preliminary assessments of custody operations and their influence on healthcare access at each of CDCR's institutions and will recommend additional staffing, along with recommended changes to [10] *already established custody posts, to ensure all* *patient-inmates have improved access to health care at each institution.*

This action has been completed.

Action 1.2.2. By July 2011, the Receiver will have fully implemented Health Care Access Units and developed healthcare access processes at all CDCR institutions.

Health Care Access Units (HCAU)

The HCAUs continue to be effective in facilitating inmate access to care. All Access Quality Reports indicate that improvements in access to care are being maintained. The reported improvements indicate that healthcare access programs have the resources necessary to support healthcare operations at the current level of service. Because of these improvements, and barring any regression or inability to support the field, it is possible that operational control of the custody HCAU could be transferred back to CDCR and released from Receivership control by next fiscal year (target July 2011).

Corrections Services continues to work with CDCR to modify post orders, hours of work and days off to better facilitate access to care. Correction Services staff work with CDCR to mitigate the effect of mission changes and in the implementation of the short, intermediate and long term bed projects, to ensure that healthcare operations are not interrupted.

Operational Assessments

Corrections Services is in the process of reviewing the operations of institutions HCAU to determine the effectiveness of the positions allocated for this purpose as well as reduce any access to care barriers.

Operational assessments for all 33 institutions are scheduled to be completed by July of 2011.

Monthly Health Care Access Quality Report (AQR) Data Collection Instrument

AQR data remained stable during this reporting period. February's AQR indicated that overall 90 percent of all patient-inmates that received ducat(s) for a healthcare appointment(s) were seen by a clinical provider. Specific to custody performance, the number of inmates *Not Seen Due to Custody* represented 1.9 percent of the total number of ducats.

There were no updates to the AQR during this reporting period; all data elements remained the same. Field Operations staff met with COMPSTAT to review modifications to the data collection tool. The updates to the data collection tool will result in a report that mirrors the AQR, and it is anticipated that institutions will begin inputting 09/10 AQR data into COMPSTAT within the next month.

Corrections Services Field Operations Unit continues meeting quarterly with the Division of Adult Institutions (DAI), Associate Directors. On the agenda for these meetings are AQR trends, changes and updates, as well as discussions and development of other Field Operations functions and their association within elements of the DAI.

* * *

[18] Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce

Objective 3.1 Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions

Action 3.1.1. By January 2010, fill 90% of nursing positions.

This action has been completed.

As of February 28, 2010, which is the most recent reporting period available, over 91 percent of the nursing positions have been filled statewide (this percentage is an average of six State nursing classifications).

More specifically, the goal of filling 90 percent or higher of the Registered Nurse (RN) positions has been achieved at 27 institutions (81.8 percent of all institutions), with 4 institutions (12.1 percent) having filled 100 percent of their positions. Six institutions (18.1 percent) have filled 80 to 89 percent of their RN positions.

The goal of filling 90 percent or higher of the Licensed Vocational Nurse (LVN) positions has been achieved at 20 institutions (60.6 percent), with 6 institutions (18.1 percent) having filled 100 percent of their LVN positions. Eleven institutions (33.3 percent) have filled 80 to 89 percent of their LVN positions.

Twenty-three institutions (69.6 percent) have achieved the goal of filling 90 percent of their Psych Tech positions, with 11 institutions (33.3 percent) having filled 100 percent of their Psych Tech positions. Four institutions (12.1 percent) have filled 80 to 89 percent of their Psych Tech positions.

The following hiring-related initiatives continued during the reporting period: (1) focused recruitment continues statewide for LVNs and Psych Techs; (2) presentations at nursing schools statewide; and (3) online job postings. Nursing vacancies are posted on multiple websites including: www.ChangingPrisonHealthCare.org, www.Indeed.com, www.VetJobs.com, www.caljobs.ca.gov, and several more. Each job posting often represents multiple vacancies at an institution. Additionally, staff recently negotiated a contract with www.Monster.com for job postings on that site and access to their database of jobseeker resumes. Staff has been assigned to monitor vacancy reports and job postings to ensure that vacancies are accurately represented in all job postings.

At the following institutions: California Correctional Institution, High Desert State Prison, and Pleasant Valley State Prison nursing has experienced moderate turnover (11 to 19 percent) and moderate vacancies (11 to 30 percent vacant) as displayed in the Nursing Filled Percentage and Turnover Rate map in the February 2010 Human Resources Recruitment and Retention Report. A moderate vacancy rate (11 to 30 percent) exists at California Medical Facility, California Men's Colony, Chuckawalla Valley State Prison, Ironwood State Prison, and Sierra [19] Conservation Center. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2009 and January and February 2010. These reports are included as Appendix 5. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

Action 3.1.2. By January 2010, fill 90% of physician positions.

This action is ongoing. Progress during this reporting period is as follows:

Physician recruitment efforts continued to focus on "hard-to-fill" institutions during the reporting period. Most urban institutions have now hired their full complement of primary care providers.

As of February 28, 2010, nearly 88 percent of physician positions are filled (this percentage is an average of all three State physician classifications). More specifically, 90 percent of the Chief Medical Officer (CMO)/medical executive positions are filled; 89 percent of the CP&S positions are filled; and 87 percent of the P&S positions are filled.

Eighteen institutions (54.5 percent) have achieved the goal of filling 90 percent of their P&S positions; 16 of these institutions have filled at least 95 percent of their P&S positions. Five institutions (15.1 percent) have filled 80-89 percent of their P&S positions.

While the Central Valley region, as well as Chuckawalla Valley State Prison, continue to be "hard-to-fill," the following institutions decreased their vacancy rate during this reporting period: Avenal State Prison, California Correctional Institution, Centinela State Prison, California Men's Colony, California Medical Facility, Corcoran State Prison, Mule Creek State Prison, North Kern State Prison, Pelican Bay State Prison, California State Prison Solano, Salinas Valley State Prison, and Valley State Prison for Women. Of special note, Centinela State Prison; California State Prison, Corcoran; Pelican Bay State Prison; and Valley State Prison for Women have now filled 100 percent of their P&S positions.

Job postings continue to be placed online at the Department's recruitment website, other online job boards, and recruiters continue to visit residency programs and other recruitment events. Additionally, a RFP for physician and executive search services was released in March 2010. These services will be used to recruit a statewide executive leader, as well as assist with staffing at the "hard-to-fill" institutions and the medical executive positions.

A high vacancy rate (30 percent or higher) and turnover rate (20 percent or higher) exists at Correctional Training Facility and Chuckawalla Valley State Prison as displayed in the Physicians Filled Percentage and Turnover Rate map in the February 2010 Human Resources Recruitment and Retention Report. A high turnover rate (20 percent or higher) and moderate vacancy rate (11 to 30 percent vacant) exists at Avenal State Prison; California State Prison, Los Angeles County; High Desert State Prison; Pelican Bay State Prison; and Salinas Valley State [20] Prison. For additional details related to vacancies and retention, refer to the Human Resources Recruitment and Retention Reports for December 2009 and January and February 2010. These reports are included as Appendix 5. Included at the end of each Human Resources Recruitment and Retention Report are maps which summarize the following information by institution: (1) Physicians Filled Percentage and Turnover Rate, (2) Physicians Filled Percentage, (3) Physician Turnover Rate, (4) Nursing Filled Percentage and Turnover Rate, (5) Nursing Filled Percentage, and (6) Nursing Turnover Rate.

Objective 3.2 Establish Clinical Leadership and Management Structure

Action 3.2.1. By January 2010, establish and staff new executive leadership positions.

Action 3.2.2. By March 2010, establish and staff regional leadership structure.

This action is ongoing. Progress during this reporting period is as follows:

Since the CEO examination was launched on December 24, 2008, 476 CEO applicants have been added to the certification list and 12 hires have been completed. The pool of CEO candidates is very competitive and interest remains high.

Strategically, CEO positions will be filled statewide and these individuals will then play a pivotal role in establishing the remainder of the clinical leadership structure. The interview and hiring process for all CEO positions is underway, and several hires are pending.

Since the Receiver's Nurse Executive examination commenced in September 2008, 322 Nurse Executive applicants have been added to the certification list and nine Nurse Executives have been hired.

Since the Receiver's Medical Executive examination was launched in December 2008, 112 Medical Executive applicants have been added to the certification list. Nine Medical Executives have been hired.

A fifth Receiver's Career Executive Assignment, Receiver's Health Care Administrator that will be responsible for all medical administration subject areas that are not clinical in nature, was approved by the State Personnel Board on December 17, 2009. Prior to filling jobs covered by this classification, a salary study must be conducted and salaries approved by the Department of Personnel Administration.

Objective 3.3. Establish Professional Training Programs for Clinicians

Action 3.3.1. By January 2010, establish statewide organizational orientation for all new health care hires.

This action is ongoing. Progress during this reporting period is as follows:

Status of New Employee Orientation and Training

Health Care New Employee Orientation (HCNEO) was delegated to each institution to comply with the January 2010 implementation date. This was done through formal training for trainers

* * *

[54] Section 8
Conclusion

This report reflects continuing success in recruiting and maintaining a highly qualified clinical staff. There is also continuing success in overcoming most obstacles to access to care. In sum, we are doing a better job in managing the "people" aspect of the prison health care system.

For the next several years, we will be concentrating a huge amount of our implementation energies upon the "information" piece of health care. The information piece includes electronic scheduling, the mental health tracking system, conversion of paper health records into digital health records, creation of a live electronic health record, more reliable and timely information flows for radiology and laboratory results, and increased utilization of telemedicine technologies to expand cost-effective access to care.

For CDCR, these information systems represent a quantum-leap into the information age. During the last two years, we have been building the technology infrastructure for these information systems, including acquisition of a modern fiber-based network to each institution, building out local area wireless and wired networks, installing 1,000's of switches and up to 10,000 network drops at institutions, and installing thousands of desktops and laptops in the field. These numbers are large because CDCR is jumping forward from 1970s technologies to 21st century technologies.

We will also be focusing attention upon completing the "facilities" aspect of our turnaround plan. We have had very positive meetings with legislators this Spring to describe the construction plan that is jointly sponsored by the Administration and the Receivership, and we are within days or weeks of final approval by the Legislature. Construction and population reduction remain of critical importance to our efforts since the continuing overcrowding that exists within CDCR's adult institutions stands as a significant obstacle to the delivery of care.

Achieving a
Constitutional Level of Medical Care
In
California's Prisons
Amended Fifteenth Tri-Annual Report of the
Federal Receiver's Turnaround Plan of Action

October 4, 2010

* * * *

[5] Section 1
Executive Summary

In our second Tri-Annual reporting for 2010, we recognize and share the accomplishments achieved by prison healthcare stakeholders and advocates. While we continue to be faced with unprecedented budget challenges, managing a diverse stakeholder process system, and severe overcrowding, progress has continued toward attaining the Vision and Mission outlined in the Receiver's Turnaround Plan of Action (RTPA). Highlights of progress include the following:

- Prison Healthcare Chief Executive Officer (CEO) – Since the CEO examination was launched on December 24, 2008, 504 CEO applicants have been added to the certification list and 21 hires have been completed. The pool of CEO candidates is very competitive and interest remains high with 3 CEO positions left to fill for oversight of 33 institutions.

- Prison Healthcare Nurse Executive – Since commencement of the examination in September 2008, 336 Nurse Executive applicants have been added to the certification list and 10 Nurse Executives have been hired.

- Prison Healthcare Medical Executive – Since launching of the examination in December 2008, 143 Medical Executive applicants have been added to the certification list and 12 Medical Executives have been hired.
- The Request for Proposal (RFP) to obtain a medical services network from a statewide provider network company was released October 20, 2009 and the contract was approved on June 28, 2010. CPHCS and Health Net Federal Services, LLC (Health Net) have partnered to develop and maintain a statewide network of healthcare providers for all 33 institutions.
- Medical invoice processing activity has continued to be streamlined for efficiency through the use of Third Party Administrators (TPA) and system enhancements. Claims processing continues to be within the 30-day mandated timeframe. The Two-Year Post Audit effort has resulted in $18.4 million in refunds as of August 2010.
- California Health Care Facility (CHCF) – During this reporting period, the 30-Day Letter for the California Health Care Facility (CHCF) and two of the former Division of Juvenile Justice (DJJ) facilities (DeWitt Nelson and Estrella Correctional Facility) were submitted to the Joint Legislative Budget Committee (JLBC) in June 2010. These projects were approved by the Public Works Board (PWB) and received Pooled Money

Investment Board (PMIB) loan approval. The 30-Day Letter for the remaining DJJ facility (Herman G. Stark) was submitted to the JLBC on August 18, 2010.

While we continue to make strides in many important areas, the momentum of these efforts continues to be affected by the State's budget and fiscal crisis and severe overcrowding in the prisons. The budget and fiscal crisis is likely to continue for the foreseeable future, and the Receivership is doing everything it can to reduce expenditures without cutting into core healthcare areas. However, productivity has been impacted throughout the organization, and coupled with some staff turnover, certain projects and initiatives have been delayed in their [6] implementation. Due to these factors, this report will reflect extensions on some of the objectives and action item dates to fulfill the goals.

Moreover, although the Administration has made some proposals to the Legislature to reduce prison population and overcrowding (in part to address the state's budget crisis), so far, those proposals have not been embraced by the Legislature and none of them have yet been implemented. CDCR's prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care.

On August 26, 2010, the Office of the Inspector General released a "Summary and Analysis of the First 17 Medical Inspections of California Prisons" ("Summary and Analysis"). In addition to summarizing the results of its first set of medical inspections, this report conducted a new "category analysis" of the data. In this analysis, OIG "sort[ed] the data from

100 key questions into five general medical categories recommended by [its] lead physician" (Summary and Analysis, p. 58). The five categories are Medication Management, Access to Providers and Services, Continuity of Care, Primary Care Provider Responsibilities and Nurse Responsibilities. (Summary and Analysis, p. 59).

The results of the category analysis show scores of 74% adherence in Continuity of Care, 74% adherence in Primary Care Provider Responsibilities, and 80% adherence in Nurse Responsibilities. The results show significantly lower adherence in the categories of Medication Management (58%) and Access to Providers and Services (60%). In explaining these lower scores, the OIG concludes that "[p]risons are ineffective at ensuring that inmates receive their medications" (Summary and Analysis, p. 62), and that "[a]ccess to providers and services is poor" (Summary and Analysis, p. 64).

The low scores in medication management and access to care require further analysis and explanation, because the low score in medication management, which is primarily a nurse function, is apparently inconsistent with the higher score for nurse responsibilities. Similarly, the low score for access to providers and services is apparently inconsistent with the results we see in the monthly reports from the health care access teams (where we have been seeing greater than 85% of scheduled appointments being met).

Upon further review of operational difficulties in the field, the primary reason for the apparent inconsistencies becomes clearer. The comparatively high score in Nurse Responsibilities reflects the fact that we have largely completed those portions of the

Turnaround Plan dealing with improving the quantity and quality of nursing staffing and making sure that we are more appropriately training our clinical staff. Notwithstanding this success, we continue to be frustrated in the category of timely administration of medications, which is primarily a responsibility of the nursing staff, because of the significant overcrowding within the prisons combined with the high frequency of overcrowding-related custody controls, such as modified programs and lockdowns, that interfere with medication management processes.

[7] Overcrowding also is a primary factor causing the comparatively low score in the Access to Providers and Services category, which essentially focuses upon the timeliness of care pursuant to CDCR policies. As we report below on Action 1.2.2, our Health Care Access teams continue to be highly effective in facilitating inmate access to scheduled appointments. However, the sheer number of inmates at each facility frustrates our efforts to meet the required timelines for access to physicians and specialty providers. There are only so many hours in the day, so many slots for appointments, and so much treatment space available to handle the population.

As the remainder of our tri-annual report indicates, and as is largely confirmed by the higher scores reported by the OIG for Continuity of Care, Primary Care Providers Responsibilities, and Nurse Responsibilities, we have made demonstrable progress in developing key aspects of a functioning system of medical care. However, the OIG scores highlight the overriding challenge of trying to provide medical care in the context of a highly overcrowded prison system where there are too many prisoners for the healthcare infrastructure, and there is a high incidence of overcrowding-related violence resulting in lockdowns and modified programs that interfere with the efficacy of the medical system.

Format of the Report

To assist the reader, this Report provides three forms of supporting data:

1. *Metrics*: Metrics that measure specific RTPA initiatives are set forth in this report with the narrative discussion of each Goal and the associated Objectives and Actions. Metrics were initially included in the Ninth Quarterly Report to the court and were also published as part of the Receiver's Turnaround Plan of Action Monthly Reports beginning in October 2008. Monthly Reports for this reporting period can be viewed at the California Prison Health Care Services (CPHCS) website (http://www.cprinc.org/receiver mo.aspx).
2. *Appendices*: In addition to providing metrics, this report also references a number of documents that are provided to the reader in the included Appendices filed concurrently with this report.
3. *Website References*: Whenever possible website references are provided to the reader.

RTPA Matrix

In an effort to provide timely and accurate progress reports on the RTPA to the Courts and other vested stakeholders, we are introducing a new format that provides activity status by enterprise, for statewide applications/programs, and by institution, as appropriate for and in coordination with that operation.

The Enterprise Project Deployment worksheet and the Institution Project Deployment worksheet provide an illustration of the progress made towards each action item outlined in the RTPA and reported in the Tri-Annual Report. The Enterprise Project Deployment worksheet captures projects specifically assigned to the Receiver for broad administrative handling,

* * * *

FOR ARGUMENT

Supreme Court, U.S.
FILED

NOV 8 2010

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IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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NOTICE

The following documents have been omitted from the printing of this Deferred Joint Appendix. They may be found in the Appellants' Appendix to the 09-416 Jurisdictional Statement at the following pages:

Coleman v. *Schwarzenegger*/*Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK JFM P, C01-1351 TEH (E.D. Cal./N.D. Cal. Aug. 4, 2009) (population reduction plan opinion and order) 1a

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and in the Appellants' Appendix to the 09-1233 Jurisdictional Statement at the following pages:

Coleman v. *Schwarzenegger/Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK-JFM-P, C01-1351-TEH (E.D. Cal./N.D. Cal. Jan. 12, 2010) (order to reduce prison population) 1a

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA FOR THE NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE
LAWRENCE K. KARLTON, SENIOR JUDGE
BEFORE THE HONORABLE THELTON E. HENDERSON, SENIOR JUDGE

Case No. Civ. S-90-0520 LKK

RALPH COLEMAN, *et al.*,
Plaintiff,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

Case No. Civ. C-01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

REPORTER'S TRANSCRIPT

Wednesday, June 27th, 2007 – 10:30 Am

Re: Joint Motion Hearing On Plaintiffs Motions To Convene Three Judge Panel

* * * *

[18] The only one you have to decide today is the two-part test that I mentioned earlier.

JUDGE KARLTON: We are required to believe that a three judge court may be able to solve the problem. That is one of the requisites of the statute.

MR. SPECTER: Well, there would be no point in you referring it to a three judge panel if you didn't have some hope that that would be the case, but it is not a legal conclusion you have to make.

JUDGE KARLTON: All right.

MR. SPECTER: In terms of the point about whether it's the primary cause, I think, first of all, I want to make one point. And that is that the evidence is basically uncontradicted in this case.

There is not—there is not a dispute about the facts here. The inferences which one may draw from that evidence may be subject to different interpretations, but all of the evidence shows that overcrowding is a severe problem, all of the evidence shows that overcrowding is inhibiting the remedial efforts of both the courts and the Special Master and the Receiver in this case. And therefore, it is delaying the constitutional remedy.

And to my mind, if you can make that link between that it is actually causing, and I think the evidence is clear that it is, then it becomes, for legal purposes, a [19] primary cause.

And let me tell you in some sense why that is so clear. Because in these cases, which are about—we're using the word "overcrowding," but it is not exactly—it doesn't exactly fit the cases that you're presiding over.

It is true that the prisons are overcrowded in the sense that there are not enough places for people to sleep.

They've run out of beds. They've run out of room to put beds for people to sleep. But this is a case about health care services.

And in health care services cases, as you both know, the critical issues are the staffing, which is critical, and the space to support the clinical activities.

So in terms of the constitutional violations, it's in some sense a supply and demand issue. And that is you have all of these prisoners who have a certain demand for services, and the population is so great, the overcrowding is so great that the prison has not been able to supply enough services to meet that demand.

And so here — so that is a direct primary cause of the overcrowding. It's the same thing.

JUDGE KARLTON: You mean the overcrowding is a direct 3 cause of the failure to provide adequate medical and mental health care?

MR. SPECTER: Yes. Exactly.

[20] JUDGE KARLTON: You said it the other way.

MR. SPECTER: I appreciate the correction.

As both the receivers' report and Mr. Keating's report make clear, this overcrowding has also indirect effects which are inhibiting the remedy.

In Mr. Keating's report he said that there's literally not enough staff for about a third of the mentally ill population. And they've been — I don't know how many of your 70 orders were directed to staffing, but a good percentage of them over the last 15 or so years.

And in Mr. Sillen's report he questions whether there will be enough medical clinicians to staff an ever growing prison population with what they need without either bankrupting the state or taking all the doctors away from the communities, which is a scenario that nobody wants to have happen.

Does that answer your question, judge?

JUDGE HENDERSON: It does, but it only prepares me for another question.

MR. SPECTER: Okay.

JUDGE HENDERSON: You correctly stated that we must find today in this hearing whether defendant has had a reasonable amount of time to comply with previous court I orders.

Does that reasonable amount of time begin once [21] defendants are on notice that the court has found that there's overcrowding or serious overcrowding or that it is a primary cause, or is that irrelevant in our consideration?

MR. SPECTER: Well, I would say as a legal matter that it is irrelevant. It is not within the statute. But even if it were somehow—It is not within the express language of the statute certainly. Even if it was somehow implied, the evidence in the record is overwhelming that they have known that overcrowding is causing these problems for many, many, many years.

JUDGE KARLTON: But it's—Judge Henderson's question really raises a different question, I would think.

It is not a question of whether the defendants know that overcrowding has contributed in some significant way to the failure to provide constitutionally adequate care, it is a question of whether or not they know that the courts have so found.

I mean, that's the question.

Does that make any difference?

MR. SPECTER: I don't really think so. I don't—I don't think so. But even if—I mean, it is not in the language. I don't even take it from the language. But even if it were, Judge Henderson, in your order of Findings of Fact and Conclusions of Law in which you found that there was a need to appoint a Receiver, you alluded to the fact of [22] overcrowding in that order.

And I think one of the first sentences in your findings was that the prison has grown 500 percent over the last so many years. I can't remember exactly. So they're certainly on notice that you've been concerned about those issues.

And in terms of the reasonable—talking about the reasonable time, in your February 15th order you put—you said that the reasonableness of the time had to be judged in the factual context of the case, and specifically in terms of the harm that is at stake, alluding to the fact that in this case it's uncontested that one prisoner dies every six or seven—dies needlessly once every six or seven days.

And in this particular case, we have the overwhelming evidence to support the notion that a reasonable time has already passed. And Mr. Sillen's report makes clear that the remedial efforts are being significantly delayed, if not in some cases altogether prevented, from remedying the constitutional violations that exist.

Even in terms of his plan of action he says, quote: "Every element of the plan of action faces crowding-related obstacles."

And in that sense I believe that when the stakes are so high, the reasonableness of the time has to be shortened. One other point I want to make about the stakes being [23] so high flows from Judge Henderson's remarks when he was, I think, ruling from the bench or talking about the issue of the Receivership.

You said that the court's authority to remedy constitutional violations was at its highest point when the loss of life itself is a result of constitutional violations.

And I think in both of these cases we have that same point. In Coleman it's not as frequent fortunately, but it occurs in suicide after—preventable suicide after preventable suicide.

And I agree, of course, with your thought that the court's authority is at its highest when those principles of 3 life and death and serious injury are at stake.

And it is because that authority is at its highest peak that it appears to me to be a situation where if there i is a situation where the court has to take over one of the core state functions of government, in this case determining who should and should not be imprisoned, that this is it.

And I think the evidence shows that all of these all of these—none of the remedies that are reasonable will I ever be taken without court intervention.

JUDGE HENDERSON: I know this is akin to an exercise in abstraction, but indulge me.

I agree with your quoting of what I said.

MR. SPECTER: It's always a good technique.

[24] JUDGE KARLTON: It's safe to assume the judge will agree with you when you are quoting.

MR. SPECTER: I learned that a long time ago.

JUDGE HENDERSON: How do we go beyond that? So I expect the state is going to say that, yeah, but we really haven't had—We have AB 900, and we're just revving up. And you're arguing people are dying. But how do I weigh that?

Do I sit here and say: One, two, three—six days someone died?

And how many days and how many deaths are you weighing against defendants?

How do I do that?

How does Judge Karlton?

How do we say, okay, that's enough deaths?

That's an abstraction, but do you have an answer to that?

MR. SPECTER: Part of my answer was in the wisdom of the President who appointed you to the federal bench and the experience you have in making these decisions.

Our opinion as counsel for the plaintiffs is that there is no question that there are so many deaths and needless suffering and the harm is so high that it outweighs all of the efforts that the state is going to say about what plans they're going to say that will take years, years, if [25] not longer, to implement.

And it's unconscionable, I believe, for the state to have not done something immediate and instead embarked on a program of prison construction which is three, five, ten years away.

Let me just say while I'm on that point, because they will talk a lot about AB 900, which is our position that we've submitted in the briefs, but I think bears repeating here is that our position is that AB 900 will actually make the situation worse and not better.

It will make it worse because it will increase, not decrease, the number of prisoners. As I said before, this is not a case about where prisoners sleep. It's a case about the demand and supply for services.

So they're increasing the demand for services, but where's the action on the supply side?

You know, it will double the number of prisons so that there will be 32 new prisons in addition to the 30-odd ones they have already. That will make management even difficult.

It will create over 10,000 new beds. And with all of the 7.9 or 5 billion dollars the Governor is spending, all of that legislation, that big piece of legislation in that bill, and all the declarations and evidence submitted by the defendants, where is there something about staffing?

* * * *

[68] court will have to do is be much more careful about who's released and how and under what circumstances.

But that's—

MS. TILLMAN: See even—

JUDGE KARLTON: That is an issue for the three judge court, not this court. I am asking you, not telling you.

MS. TILLMAN: I would suggest, though, it indicates a dispute about causation. If only the targeted release—As Special Master Keating says, if only the targeted release of severe mentally ill inmates may actually reverse current staff and bed deficiencies and program deficiencies, then is it really the overcrowding of the entire institution that's impacting the ability to provide mental health care, or is it simply the fact that the mental health care system has not been able to come up to snuff and address the needs of the population within the *Coleman* class.

I would suggest it's the latter. And that's why you see in defendants' papers the consistent concern about the management issues that have come to play into the difficulties of establishing and implementing mental health care.

JUDGE KARLTON: I'm sorry. I don't mean to dominate.

JUDGE HENDERSON: No. No.

JUDGE KARLTON: One of the questions which I have raised and I am troubled by is whether or not this is an

* * * *

IN THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT OF
CALIFORNIA

UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284,
TITLE 28 UNITED STATES CODE

THE HONORABLE THELTON E. HENDERSON
THE HONORABLE LAWRENCE KARLTON
THE HONORABLE STEPHEN REINHARDT

No. C 01-1351 TEH

Marciano Plata, *et al.*,
Plaintiffs,
v.
Schwarzenegger, *et al.*,
Defendants.

No. CIV S90-0520 LKK JFM P

Ralph Coleman, *et al.*,
Plaintiffs,
v.
Schwarzenegger, *et al.*,
Defendants.

San Francisco, California
Monday, September 24, 2007

* * * *

[26] saving, like Mr. Specter did, an opportunity to respond to what other Intervenors state, that seems reasonable to the *Plata* Defendants.

MS. TILLMAN: Good afternoon. Lisa Tillman on behalf of the *Coleman* Defendants. We would join in Mr. Mello's comments regarding the Intervenors' role. Thank you.

JUDGE HENDERSON: Thank you.

MR. HUGHES: Charles Hughes, Riverside County District Attorney's Office, on behalf of the DA Intervenors.

We do not look to expand the role—the scope of these proceedings. I agree with the Court that, as DA Intervenors, we have a more narrow or limited role in the proceedings, in the sense of the types of evidence we would be presenting. We view our role and the types of evidence we would present as more of the impact on public safety, and impact on the criminal justice system.

I disagree with Plaintiffs' Counsel characterization, that that role only applies at the remedial phase, however. I believe that role is part and parcel of this Court's determination for whether there are less intrusive means available. How intrusive any prisoner-release order would actually be necessarily speaks to the issue of whether there are less intrusive means available.

So, we do view the DA Intervenors' roll as limited to impact-style evidence, but I don't see it as applying only at [27] the remedial phase.

JUDGE KARLTON: Counsel, before you move, tell me what kind of evidence you think the DAs would have, relevant to public safety or whatever, that would not be appropriate for the California Defendants to present, in a sense, preempting your presentation, if you Will.

MR. HUGHES: Well, there are many impacts that a prisoner-release order might have within any given county that the District Attorney's Office would be familiar with. Such as, the effect on the ability to timely prosecute cases within a county, if local jail inmates have to be released because our jails are overcrowded, because people who have already been sentenced to state prison can't go there.

So, for instance, an inmate goes to trial in Riverside County, gets convicted of a crime for which he must go to state prison. If the Court has put a cap on the state prison population and we are at that cap, then that inmate must stay in the Riverside County jail.

We are already under a federal cap within our jail. So there's not room in our end for the next person who gets arrested for a crime and who is now pending trial. That inmate would be out of custody. Whether that inmate has any incentive to plead guilty, or timely go to trial, is—is an issue that

D.A.'s offices would be uniquely situated to present. There are others, but that's an example.

[28] JUDGE KARLTON: Thank you.

MR. HUGHES: Any other questions? Thank you.

MS. BARLOW: Good afternoon again, Your Honor. Kimberly Hall Barlow, Jones & Mayer, on behalf of the Sheriff, Police Chiefs, Corrections, and Probation parties Intervenors.

We also believe that there are two issues on which the Intervenors, at least my client Intervenors—and I correct myself, it is actually 67 parties I represent, but I'll still only take a week—the first issue we think is also important for the Defendant Intervenors to offer evidence on, and that is—

JUDGE KARLTON: Would you move that microphone down just a bit?

MS. BARLOW: Certainly.

JUDGE KARLTON: Thank you.

MS. BARLOW: That is the issue of alternatives. For example, representing the probation officers gives us a unique opportunity to present alternatives, in terms of probation reforms, probation alternatives that could solve some of the problem, so that we don't even need to get to the issue of what might the local impacts be of a release order.

So we believe that those are issues that are uniquely able to be presented by our Sheriffs, and those people who deal with some of these—this population, both at the front end and at the back end, if you will.

[29] So, right now, you have the prison folks in the middle. We are dealing with them before they get to the prison system and after they come out of the prison system. And we have an opportunity to offer evidence both on the alternatives to the prison release or cap that's being proposed, and we have an opportunity to provide you unique evidence from different perspectives—city police chiefs, county sheriffs—on the jails, both local and county, as well

as the probation officers and corrections at the local level, in terms of impacts to the community if a release order were entered.

Frankly, Your Honors, we don't know that the State is in a position to offer all of that evidence—and since we just joined the fray, as it were, we believe that that is an important function for our role as Intervenors.

JUDGE REINHARDT: Well, you suggest you have lesser alternatives involving probation officers that you could tell us about. Such as what?

MS. BARLOW: Well, Your Honor, there are several programs that are actually underway to deal with the—the 18-to-25-year-old population; 25 percent of the in-custody population in the state prison is in that age range.

Those are the unique population that we think could be perhaps diverted out of the system so that they don't have that 70 percent recidivism rate that seems to be getting prisoners back to the system over and over again.

[30] If we can provide—

JUDGE REINHARDT: You are talking about procedures that would result in the release of prisoners?

MS. BARLOW: We are talking about both post-release probation facilities, including reentry facilities, where there's discussions happening between probation and the Sheriffs and the State, under AB 900.

But also, before they get to that system—it's worked very well in the juvenile court system, where we have reduced the juvenile population, the juvenile prison population, if you will, in the state—similar programs could be used to target this young group that is representing a rather sizable proportion of prisoners, and yet, we believe, are in a position to be diverted ut of the long-term prison population.

JUDGE REINHARDT: Thank you.

MS. BARLOW: You are welcome, Your Honor. Thank you.

MR. KAUFHOLD: Your Honor, Steve Kaufhold, from Akin, Gump, Strauss, Hauer & Feld, on behalf of the Assembly and Senate Intervenors.

There are three legal issues that we are interested in contributing to, and then one practical issue that I wanted to mention as well.

On the legal side, in terms of the arguments and possibly testimony, I believe we could provide unique and helpful testimony and information regarding AB 900, how it is [31] intended to function, and what the appropriate timing of any possible order would be.

Second, we are interested in providing testimony possibly, and certainly analysis, regarding what alternatives are open to the Court.

Third, our clients also believe that they can and should have some input with respect to the public-safety impact of any cap order or any prisoner-release order.

And finally, as a practical matter, we believe, to the extent the Court is interested in discussing some settlement of the pending litigation or some informal resolution, that there should be a place at the table for our Intervenor clients as well, and that we could be productive contributors to that process.

JUDGE KARLTON: That latter—hang on.

(Off-the-Record discussion)

JUDGE KARLTON: I want to raise an issue with you. It might be just my problem. You are not the Assembly, you are biased. They are not the Senate, they're a subset.

It may well be that under the statute, they have a right of intervention. They also have to meet a constitutional standard, of standing. Is there a problem with your—with that leg of your being the proper Intervenors?

MR. KAUFHOLD: No, I don't think there is any problem with that at all, Your Honor. I think the statute is written in

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[33] MR. KAUFHOLD: Thank you, Your Honors.

MS. FUENTES: Theresa Fuentes, from Santa Clara County.

As a preliminary matter, in the Court's September 19th order, you asked that the County Intervenors, the five counties–

JUDGE KARLTON: I'm sorry.

MS. FUENTES: Santa Clara, Santa Barbara, San Mateo, Contra Costa, and Solano—select a lead counsel to speak in these proceedings, and those five counties have agreed that Santa Clara County would be the lead counsel for these proceedings.

JUDGE HENDERSON: Thank you.

MS. FUENTES: The counties see their role in these proceedings as, as also being limited and affecting—there is substantial evidence, medical, mental health—if prisoners are released into the community, there will be housing issues to address, mental health issues to address, regular health issues, public health issues, and all of those impact on public safety.

In addition, if there are caps, at the—at the state-prison level, it would impact the local level in terms of ability to provide mental health care and medical care. If these prisoners are not able to receive that care in the state prisons, they also will not be able to receive it at the local level, either.

[34] And so, that does impact not only the—the—not only—it impacts the cause but in addition, the ability to remedy the problem.

Thank you.

JUDGE HENDERSON: Thank you, Counsel.

Any other Intervenors or—okay. Mr. Specter? MR. SPECTER: Donald Specter, for the Plaintiffs.

That was—thank you for allowing me to hear that.

That was very helpful.

I'll go down the list. The DA Intervenors, we understand, and I—we understand the relevance of the DA Intervenors wanting to present arguments and impact on public safety, as to any kind of release order. That seems relevant to us.

The other part of their comment, I think they're a little confused, maybe because the statute's a little un—well, I don't know.

But, the DAs, I think, misstated the legal standard. The alternatives to incarceration may be relevant to the remedy, but they are not relevant to whether to issue a remedy. That is, are there any other orders which could fix the medical and mental health care in the prisons that would be effective. And that's something that the State's familiar with and should defend, if there are any.

So, the DA—I think the DA's role should be limited

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[1] IN THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

No. Civ S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

TRANSCRIPT OF PROCEEDINGS

San Francisco, California
Friday, June 26, 2008

* * * *

[12] Shorter, your honor. We want to reserve our right not to add evidence that is duplicative of the defendants' evidence on that point, but we do want to have the ability to reserve our right to develop independent evidence and potentially provide you with expert—independent expert evidence on that point. But I would think that would be the type of testimony—and I would be interested in hearing from my colleagues—that could be presented within a day or two by the intervenors, and that's the intervenors collectively not per intervenor.

JUDGE KARLTON: So your view is if we bifurcate, Intervenors' case taking a day or two?

MR. KAUFHOLD: Correct, Your Honor. And we absolutely want to participate in that portion should the court determine that bifurcation is appropriate.

JUDGE KARLTON: In your view—I'm sorry. I don't need to—in your view, would bifurcation lead to a more ready disposition, or would trying the whole case at once and getting the whole view a better posture?

MR. KAUFHOLD: Our clients don't have a position on that, your honor, and we're pleased to do it however you think is most appropriate. There is, of course, the possibility that you would determine that overcrowding is not the primary cause and have some economy, but I think that we're pleased to go forward however you believe is appropriate.

JUDGE KARLTON: Does anybody else have—I'm sorry,

* * * *

[14] JUDGE HENDERSON: yes.

MR. SPECTER: Anyway, that's our position.

MR. BIEN: Michael Bien on behalf of *Coleman* Plaintiffs.

I also say that some of the witnesses are going to be testifying on both issues, so I'm not sure there's going to be a lot of efficiency.

MS. KECK: Anne Keck for the Sonoma County Intervenors.

Your Honors, we believe that bifurcation may very well be appropriate, but urge the court to bifurcate—to be very clear in the bifurcation.

For example, Sonoma County Intervenors do not intend to present any evidence on the question as to whether overcrowding is the primary cause of the constitutional violation. However, the code section combines that with the issue of whether there are alternative remedies available other than a prison relief order. We believe that should be put with the remedy section, because we do believe we have evidence to put in that regard.

So it makes a difference as to how the Court bifurcates the issue, but we don't intend to present any evidence on the constitutional violation issue. Thank you.

JUDGE HENDERSON: Thank you, Counsel.

MS. FUENTES: The County Intervenors agree with [15] that.

MS. BARLOW: Kimberly Hall Barlow, Jones & Mayer, on behalf the sheriffs, police chiefs and chief probation officers.

We would concur with the legislative intervenors that we don't take a position. It's entirely up to the court. And I agree that I think we could, the intervenors, collectively could put on their evidence on the primary cause issue in a day or less. Thank you.

MR. MITCHELL: William Mitchell. We are the same position as previously stated by the other intervenors.

MS. EAST: Rochelle East for the state defendants.

JUDGE KARLTON: I'm sorry. I can't hear you.

MS. EAST: Rochelle East for the state defendants.

Likewise, we do not have a problem bifurcating the trial. We would only note there was a bit of confusion with the bifurcation and the overlap of some of those issues. That was the only thing. Thank you.

JUDGE HENDERSON: Thank you. Anyone else? Thank You.

Now let's turn to the issue of dispositive motion schedule. In particular, we would like to hear from the parties and intervenors on two issues. First, is there a need for such a schedule. And, secondly, should the court adopt plaintiffs' proposal for defendants to provide more detail

* * * *

[32] All right. We're just repeating ourselves now. Thank you.

MS. TILLMAN: Thank you.

JUDGE HENDERSON: Anyone else on the dispositive motion schedule? Okay. Thank you.

Let's turn to discovery issues. First, the court denies defendant's request to modify the magistrate judge's order regarding time to respond to discovery. That order which requires responses to discovery within 21 days of service will remain in full force and effect.

We'd like to hear from counsel on the following discovery-related issues:

One, when should the non-expert and expert discovery cutoffs be?

Secondly, why do plaintiffs need three weeks after disclosing experts to prepare expert reports?

Three, should trial witnesses be disclosed in advance by August 1st?

Four, should the court adopt defendant's proposal to prohibit additional site inspections of CDCR facilities?

Again, why don't we start with plaintiffs? Do you want me to repeat those questions? Do you have all four?

MR. SPECTER: I think so, but I'm going to bifurcate the response, if that's okay. Mike is going to take some of these.

[33] I'm just going to respond to the trial witnesses and site inspections, if you like, and I'll let Mr. Bien do the rest. On the trial witnesses, I think it would make the case go a lot faster if we could depose each other's trial witnesses.

It seems eminently reasonable, and it seems to me the defendants are close to our position in that they say that they don't disagree with that, they just would limit the depositions to only those people that they designate as trial witnesses, which is clearly not appropriate, because it would hide evidence. So we think that's an order that will be in the court's best interest and in the parties' best interest.

As to the site inspections, our position is that we were ready to go to trial after the site inspections were conducted. They were conducted in the fall of last year. And, as you recall, there was a February trial date, and we were ready to go to trial on the issue of the primary cause of overcrowding as of February of this year. We're still ready, just as long as the delay that's occasioned wouldn't prejudice us, our ability to make the appropriate record.

So in the sense that if the defendants are not going to come at some point, or the intervenors are not going to come at some point and say, well, everything's changed, you know, what they saw then is different than what it is now, then we're fine, we don't need any site inspections, and we think the [34] Experts' got enough of a sense of the prisons at that time to give the court—they've all written their reports. I don't think they've been filed, but they have been given to the other side which provide all the evidence. If we do the site inspections, we will have to redo those over again, and it will be a fair amount of work.

So our preference would be not to duplicate it, because it's expensive and it's already been done, but we don't want to get sandbagged later. That's all.

JUDGE HENDERSON: Mr. Bien.

MR. BIEN: I'll address the other two questions.

In terms of the idea of disclosing the names of our experts and their identities and then having a period of time before they file their reports, I think the idea, and we thought that was a good idea, in terms of letting everyone get experts together and know what topics are at issue so we don't have—less of a need for rebuttal kind of experts, sort of you know who the experts are and the reports are coming before their depositions. It's more just a matter of convenience and efficiency rather than any dire necessity.

In terms of the discovery cutoffs, we feel that the dates suggested by both the intervenors and defendants are extremely limiting, especially in light of the stay that was in effect for the last thirty days. We served little or no discovery since February. There's been just some clean-up on [35] matters that were hanging, and we have done no discovery of the intervenors, other than something that was filed well before the first stay. And the odds of us being able to serve discovery on Monday and get answers and finish everything in 45 days is very limited.

We, of course, will expedite everything, but our experience is there is going to need to be more time than that, given the kinds of objections and normal kind of process that happens.

Very little phase two discovery was done, as you recall, and we really, in the interest of the settlement process, held back and didn't do discovery during that period, even while discovery was open. We did some clean up of things that were hanging and finished some of the motions that were pending before magistrate judge moulds.

JUDGE HENDERSON: Thank you. Counsel for CCPOA.

MS. LEONARD: Yes, thank you, Your Honors.

We took no position as to your questions relating to expert discovery, but we would stand with plaintiffs in stating that it would be a convenience to all of the parties in terms of scheduling on this expedited schedule to do—to identify trial witnesses in advance. We do have a limited time. We want to keep the limited time. We all want to get to trial on the 17th. I think it would be a matter of extreme efficiency.

With respect to site visits, of course, every day is [36] a site visit for us, and we would take no position.

JUDGE HENDERSON: Let me make sure I understood you. It would be an inconvenience to disclose witnesses in advance?

MS. LEONARD: No, no, Your Honor. On the contrary, it would be a convenience to disclose them to expedite the discovery schedule and deposition.

MS. EAST: Your Honor, Defendants' position in particular is that the percipient and paper discovery, that that cutoff be sooner, ideally, versus the date we proposed, which I believe is August 15th. The reason for that is, like plaintiffs, we, too, are really gearing up and going into a pretrial mode. Our feeling is that, especially with that twenty-day discovery turnaround, that six weeks of further discovery—and, as you know, a great deal has already taken place—that should be enough to get us to where we need to go.

We believe the time spent after the close of that kind of discovery is better spent preparing the testimony by affidavit, preparing the court's binders, authenticating documents, for example, those sorts of things. So while certainly we believe that schedule the defendants proposed is certainly one that we'd offer. The date in particular, we feel, is appropriate is to have that discovery cutoff in the middle of august rather than later.

As far as the expert testimony—again, there's [37] probably some room, and we're probably closer to plaintiffs, and certainly—we would certainly be willing to give there. That's not our issue, not like the prior one.

Again, the trial witnesses, we are happy to disclose those. But, again, our position is that the depositions be limited to those who—that we depose the trial witnesses and start really focusing this discovery. Our position is conducting discovery in order to get potentially more discovery, that that time has probably come and gone, and, certainly, we've produced a great deal of discovery to that end.

JUDGE KARLTON: May I inquire?

The plaintiffs say that they've got to do visitations, because they fear that the defendants are going to argue that any position that they take is out of—is no longer—things have changed. Are your clients willing to stipulate that the testimony presented by the plaintiffs will not be attacked as being out of date? Do you understand my question?

MS. EAST: I do, Your Honor. The problem is that the receiver is out there, and the *Coleman* master is out there. To the extent the receiver, for example, is doing things every single month—

JUDGE KARLTON: So the answer is no?

MS. EAST: I think the answer is no.

[38] JUDGE KARLTON: So then what we have to do in order to ensure we have current testimony—I ask you, not tell you—I'm sort of asking you, anyway—is let them go, because otherwise they're out of date?

JUDGE HENDERSON: If they leave that trap open and don't come in prepared—

MS. EAST: It is. It's—certainly, plaintiffs are obviously entitled to be prepared. There's no question about that.

On the other hand, what we have done are numerous site inspections. And, for example, plaintiffs' expert was out just this past month in conjunction with the settlement procedures. At some point there must be some cutoff with the site inspections.

JUDGE REINHARDT: What is the date you stop introducing changes?

MS. EAST: I think we can come to a date such as that, Your Honor, no question, because, absolutely, otherwise, it's just always changing.

JUDGE REINHARDT: So the order would not be no further site inspections, it would be after the date on which you agree that's the last time that you would say that the evidence is relevant?

MS. EAST: Agreed.

JUDGE REINHARDT: I think that, rather than just [39] have an order now, you and the plaintiffs should get together on a date.

MS. EAST: I think that's reasonable. Yes, Your Honor.

JUDGE HENDERSON: Anything further?

MS. EAST: Not from me, unless there's any questions.

JUDGE HENDERSON: Thank you.

Anyone else from Defendants or Intervenors?

MR. KAUFHOLD: Your Honor, Steve Kaufhold for the Legislator Intervenors.

I just want to underscore the point that was made about the need to have, obviously, a date certain, as you pointed out, Judge Reinhardt, but we need to base whatever decision the court makes on current or as-close-to-current information as we can, in our opinion.

We think it wouldn't do the Court, the parties, or the public any service to be talking about making a decision of the importance and magnitude that you are based on what the state of play was a year ago or months ago.

So, we think it's important, and if that means leaving open some avenues of discovery to the plaintiffs, then that's what needs to be done.

JUDGE REINHARDT: It's a proposal by the state to cut it off. So if you want to leave it open the whole time –

* * * *

[41] the cutoff date after which no evidence about subsequent changes would be appropriate?

MR. KAUFHOLD: Yes, Your Honor. Our point is that should be a date closer in time to our trial date, number one. And then number two, in the meantime, there should be reasonable limitations on the site visits, the same way there would be on any discovery, with the understanding that it would be expensive and intrusive. Our point is just there shouldn't be a deadline set in the past for stale evidence presented to the court.

JUDGE REINHARDT: I'm going to ask you a question you may not have thought of. What should that date be, from your point of view? If you are prepared to say, "I'm not *prepared*," that's fair enough.

MR. KAUFHOLD: I'm not prepared, but I'm going to answer you anyway. I would think something more toward the end of the summer would be appropriate, as opposed to freezing the state of the record now.

JUDGE KARLTON: The end of August?

MR. KAUFHOLD: Something more like that. Thank you, your Honors.

JUDGE HENDERSON: Thank you, Counsel.

Any other comments on that topic? Okay. I've come to the end of my questions. Do either of you have any questions you want to put to counsel?

* * * *

[1] UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
BEFORE THE HONORABLE THELTON E.
HENDERSON, LAWRENCE K. KARLTON, AND
STEPHEN REINHARDT

NO. C 01-01351-TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENNEGER, *et al.*,
Defendants.

NO. CIV S90-0520-LKK

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENNEGER, *et al.*,
Defendants.

San Francisco, California
Monday November 10, 2008
1:35 p.m.

TRANSCRIPT OF PROCEEDINGS

* * * *

[6] behalf of the *Coleman* defendants. Also here on behalf of the *Coleman* defendants are Connie LeLouis

and Danielle O'Bannon, from the Attorney General's office. Thank you.

MR. MITCHELL: Good afternoon. William Mitchell, with the District Attorney Intervenors.

MS. BARLOW: Good afternoon, your Honors. Kimberly Hall Barlow, on behalf of the 67 Law Enforcement Intervenors: sheriffs, police chiefs, chief probation officers.

MS. KECK: Good afternoon, your Honors. Anne Keck, Deputy County Counsel, on behalf of the Sonoma County Intervenors.

MS. FUENTES: Good afternoon, your Honor. Theresa Fuentes, on behalf of Santa Clara County, and also as lead counsel for the County Intervenors.

MR. KAUFHOLD: Good afternoon, your Honor. Steve Kaufhold, from Akin, Gump, Strauss, Hauer, & Feld, for the Legislative Intervenors. I think we're all right.

JUDGE HENDERSON: Okay. Good afternoon.

Welcome. We're going to begin. As you can see, Judge Karlton is in Sacramento, and is appearing by video.

We're going to begin with rulings on the motions *in limine*. And those rulings are as follows. And we will not be following up with written explanations of these rulings.

Plaintiffs' motion *in limine* number one is granted as [7] to the exclusion of witnesses from the courtroom and the provision of transcripts to witnesses who have not yet testified. The motion is denied as to the provision of filed testimony to witnesses.

Plaintiffs' motion *in limine* number seven is granted as to Mr. McIntosh's testimony regarding the survey. As to Mr. McIntosh's testimony of the rate of disease, the motion is denied if such testimony is based on the PPIC report, but is otherwise granted.

Defendants' motion *in limine* number six to exclude evidence of settlement discussions is granted.

This ruling shall also extend to exclude the referee's report from evidence.

Defendants' motion in limine number 13 to limit the trial testimony of Dr. Beard to the scope of his deposition is granted.

The motion to exclude testimony by Mr. Hennessee is denied.

The Law Enforcement Intervenors' motion *in limine* regarding the testimony of Dr. Austin is denied, except that plaintiffs may not introduce evidence of any analysis by Dr. Austin of the documents relied on by Mr. Dyer and by Mr. Powers that Dr. Austin performed after his deposition.

All other motions *in limine* are denied.

As to the parties' motions to exclude hearsay from

* * * *

[28] Say it five different times in five different ways, is the thing that slows—

And I'm not just talking about the intervenors. Plaintiffs do it, too. And they make their point.

And it's our plan to say, "Asked and answered. We've heard it." And we will be pushing that. And I think that will move the trial along, so be ready for that.

Make your point. Assume that all three of us heard it. And, if not, one of us heard it. And if not, our law clerk will hear it and tell us about it. So I think that will move things along faster.

I'm going to go over one more point. And then I will go to plaintiffs' table to see if there are any other housekeeping matters or other matters we need to discuss, and then do the same thing with defendants and intervenors.

The other thing—let me—we will now hear evidence on whether defendants are in Constitutional compliance. There was a request for a ruling on that. Any such arguments are simply not for this Court to consider, and would instead be properly presented to the individual *Plata* and *Coleman* courts.

The role of this Court is to determine first whether overcrowding is a primary cause of the Constitutional violations at issue in both *Plata* and *Coleman*; and secondly, if so, whether a prisoner release order is appropriate. So we [29] will not be hearing any evidence on whether defendants are in Constitutional compliance.

And, with that, let me ask if there are any additional matters we need to discuss or cover today. First, plaintiffs.

MR. BIEN: We've tried to work through most of our procedural things.

One issue that we wanted—I think everyone wanted to raise with the Court is dealing with deposition excerpts, and how—what process should be undertaken.

We had thought we had an agreement on it between us, and apparently we do not; but we have submitted deposition excerpts. And is there a schedule for objections to those? And how would the—does the—how does the Court want them addressed in terms of physically providing the pages to the Court, or a list of the pages? Just the procedure of it.

MS. JOHNSON: Well, good afternoon, your Honor. Anne Johnson, on behalf of the defendants.

JUDGE HENDERSON: Mm-hm.

MS. JOHNSON: We designated three depositions. They have designated 44. So we would ask—

JUDGE KARLTON: I'm sorry. I can't hear you, ma'am.

MS. JOHNSON: The defendants designated three depositions, and plaintiffs have designated 44. So the defendants would ask for some time to work through objections

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[1] [Seal] Office of the Governor

ARNOLD SCHWARZENEGGER
THE PEOPLE'S GOVERNOR

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Proclamation

REI

10/04/2006 Print Version

Prison Overcrowding State of Emergency Proclamation

PROCLAMATION
by the
Governor of the State of California

WHEREAS, the California Department of Corrections and Rehabilitation (CDCR) is required by California law to house inmates committed to state prison; and

WHEREAS, various trends and factors, including population increases, parole policies, sentencing laws, and recidivism rates have created circumstances in which the CDCR is now required to house a record number of inmates in the CDCR prison system, making the CDCR prison system the largest state correctional system in the United States, with a total inmate population currently at an all-time high of more than 170,000 inmates; and

WHEREAS, due to the record number of inmates currently housed in prison in California, all 33 CDCR prisons are now at or above maximum operational capacity, and 29 of the prisons are so overcrowded that the CDCR is required to house more than 15,000 inmates in conditions that pose substantial safety risks, namely, prison areas never designed or intended for inmate housing, including, but not limited to, common areas such as prison gymnasiums, dayrooms, and program rooms, with approximately 1,500 inmates sleeping in triple-bunks; and

WHEREAS, the current severe overcrowding in 29 CDCR prisons has caused substantial risk to the health and safety of the men and women who work inside these prisons and the inmates housed in them, because:

With so many inmates housed in large common areas, there is an increased, substantial risk of violence, and greater difficulty controlling large inmate populations.

[2] With large numbers of inmates housed together in triple-bunks, there is an increased, substantial risk for transmission of infectious illnesses.

The triple-bunks and tight quarters create line-of-sight problems for correctional officers by blocking views, creating an increased, substantial security risk.

WHEREAS, the current severe overcrowding in these 29 prisons has also overwhelmed the electrical systems and/or wastewater/sewer systems, because those systems are now often required to operate at or above the maximum intended capacity, resulting in an increased, substantial risk to the health and safety of CDCR staff, inmates, and the public, because:

Overloading the prison electrical systems has resulted in power failures and blackouts within the prisons, creating increased security threats. It has also damaged fuses and transformers.

Overloading the prison sewage and wastewater systems has resulted in the discharge of waste beyond treatment capacity, resulting in thousands of gallons of sewage spills and environmental contamination.

And when the prisons "overdischarge" waste, bacteria can contaminate the drinking water supply, putting the public's health at an increased, substantial risk.

WHEREAS, overloading the prison sewage and water systems has resulted in increased, substantial risk of damage to state and privately owned property and has resulted in multiple fines, penalties and/or notices of violations to the CDCR related to wastewater/sewer system overloading such as groundwater contamination and environmental pollution; and

WHEREAS, overcrowding causes harm to people and property, leads to inmate unrest and misconduct reduces or eliminates programs, and increases recidivism as shown within this state and in others; and

WHEREAS, in addition to all of the above, in the 29 prisons with severe overcrowding, the following circumstances exist:

Avenal State Prison has an operational housing capacity of 5,768 inmates, but it currently houses 7,422 inmates, with 1,654 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 64 incidents of assault/battery by inmates — 31 of them against CDCR staff — along with 15 riots/melees, and 27 weapon confiscations.

The California Correctional Center has an operational housing capacity of 5,724 inmates, but it currently houses 6,174 inmates, with 450 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 128 incidents of assault/battery by inmates — 16 of them against CDCR staff — along with 34 riots/melees, and 21 weapon confiscations.

[3] The California Correctional Institution has an operational housing capacity of 4,931, but it currently houses 5,702 inmates, with 771 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 125 incidents of assault/battery by inmates — 79 of them against CDCR staff — along with 5 riots/melees, and 57 weapon confiscations.

Centinela State Prison has an operational housing capacity of 4,368, but it currently houses 4,956 inmates, with 588 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 141 incidents of assault/battery by inmates — 30 of them against CDCR staff — along with 10 riots/melees, and 151 weapon confiscations.

The California Institution for Men has an operational housing capacity of 5,372, but it currently houses 6,615 inmates, with 1,243 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 170 incidents of assault/battery by inmates — 57 of them against CDCR staff — along with 21 riots/melees, and 47 weapon confiscations.

The California Institution for Women has an operational housing capacity of 2,228, but it currently houses 2,624 inmates, with 396 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 65 incidents of assault/battery by inmates — 26 of them against CDCR staff and 6 weapon confiscations.

The California Men's Colony has an operational housing capacity of 6,294, but it currently houses 6,574 inmates, with 280 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 151 incidents of assault/battery by inmates — 33 of them against CDCR staff — along with 11 riots/melees, and 29 weapon confiscations.

The California State Prison at Corcoran has an operational housing capacity of 4,954, but it currently houses 5,317 inmates, with 363 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 147 incidents of assault/battery by inmates — 58 of them against CDCR staff — along with 5 riots/melees, and 111 weapon confiscations.

The California Rehabilitation Center has an operational housing capacity of 4,660, but it currently houses 4,856 inmates, with 196 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 65 incidents of assault/battery by inmates — 28 of them against CDCR staff — 9 riots/melees, and 34 weapon confiscations.

The Correctional Training Facility has an operational housing capacity of 6,157, but it currently houses 7,027 inmates, with 870 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 85 incidents of assault/battery by inmates — 26 of them against CDCR staff — along with 9 riots/melees, and 27 weapon confiscations.

Chuckawalla Valley State Prison has an operational housing capacity of 3,443, but it currently houses 4,292 inmates, with 849 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 50 incidents of assault/battery by inmates — 11 of them against CDCR staff — along with 5 riots/melees, and 21 weapon confiscations.

[4] Deuel Vocational Institution has an operational housing capacity of 3,115, but it currently houses 3,911 inmates, with 796 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 114 incidents of assault/battery by inmates — 54 of them against CDCR staff — along with 7 riots/melees, and 37 weapon confiscations.

High Desert State Prison has an operational housing capacity of 4,346, but it currently houses 4,706 inmates, with 360 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 351 incidents of assault/battery by inmates — 44 of them against CDCR staff — along with 6 riots/melees, and 289 weapon confiscations.

Ironwood State Prison has an operational housing capacity of 4,185, but it currently houses 4,665 inmates, with 480 inmates housed in areas designed for other purposes. At the same time in the last year, there were 96 incidents of assault/battery by inmates — 19 of them against CDCR staff — along with 14 riots/melees, and 52 weapon confiscations.

Kern Valley State Prison has an operational housing capacity of 4,566, but it currently houses 4,686 inmates, with 120 inmates housed in areas designed for other purposes. At the same time in the last year, there were 146 incidents of assault/battery by inmates — 60 of them against CDCR staff — along with 10 riots/melees, and 46 weapon confiscations.

The California State Prison at Los Angeles has an operational housing capacity of 4,230, but it currently houses 4,698 inmates, with 468 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 211 incidents of assault/battery by inmates — 123 of them against CDCR staff — along with 4 riots/melees, and 101 weapon confiscations.

Mule Creek State Prison has an operational housing capacity of 3,197, but it currently houses 3,929 inmates, with 732 inmates housed in areas designed for other purposes. At the same time in the last year there were 65 incidents of assault/battery by inmates — 35 of them against CDCR staff — along with 1 riot/melee, and 28 weapon confiscations.

North Kern State Prison has an operational housing capacity of 5,189, but it currently houses 5,365 inmates, with 176 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 135 incidents of assault/battery by inmates — 43 of them against CDCR staff — along with 16 riots/melees, and 70 weapon confiscations.

Pelican Bay State Prison has an operational housing capacity of 3,444, but it currently houses 3,604 inmates, with 160 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 256 incidents of assault/battery by inmates — 88 of them against CDCR staff — along with 9 riots/melees, and 106 weapon confiscations.

Pleasant Valley State Prison has an operational housing capacity of 4,368, but it currently houses 5,112 inmates, with 744 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 205 incidents of assault/battery by inmates — 59 of them against CDCR staff — along with 12 riots/melees, and 26 weapon confiscations.

[5] The Richard J. Donovan Correctional Facility has an operational housing capacity of 4,120, but it currently houses 4,720 inmates, with 600 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 244 incidents of assault/battery by inmates — 118 of them against CDCR staff — along with 11 riots/melees, and 96 weapon confiscations.

The California State Prison at Sacramento has an operational housing capacity of 2,973, but it currently houses 3,213 inmates, with 240 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 264 incidents of assault/battery by inmates — 159 of them against CDCR staff — along with 5 riots/melees, and 118 weapon confiscations.

The California Substance Abuse Treatment Facility and State Prison at Corcoran has an operational housing capacity of 6,360, but it currently houses 7,593 inmates, with 1,233 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 120 incidents of assault/battery by inmates — 53 of them against CDCR staff — along with 20 riots/melees, and 124 weapon confiscations.

The Sierra Conservation Center has an operational housing capacity of 5,657, but it currently houses 6,107 inmates, with 450 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 61 incidents of assault/battery by inmates — 18 of them against CDCR staff — along with 19 riots/melees, and 50 weapon confiscations.

The California State Prison at Solano has an operational housing capacity of 5,070, but it currently houses 5,858 inmates, with 788 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 60 incidents of assault/battery by inmates — 26 of them against CDCR staff — along with 4 riots/melees, and 114 weapon confiscations.

San Quentin State Prison has an operational housing capacity of 4,933, but it currently houses 5,183 inmates, with 287 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 262 incidents of assault/battery by inmates — 123 of them against CDCR staff — along with 15 riots/melees, and 118 weapon confiscations.

Salinas Valley State Prison has an operational housing capacity of 4,200, but it currently houses 4,680 inmates, with 480 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 181 incidents of assault/battery by inmates — 82 of them against CDCR staff — along with 7 riots/melees, and 91 weapon confiscations.

Valley State Prison for Women has an operational housing capacity of 3,902, but it currently houses 3,958 inmates, with 56 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 125 incidents of assault/battery by inmates — 75 of them against CDCR staff — and 15 weapon confiscations.

Wasco State Prison has an operational housing capacity of 5,838, but it currently houses 6,098 inmates, with 260 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 226 incidents of assault/battery by inmates — 97 of them against CDCR staff — along with 32 riots/melees, and 82 weapon confiscations.

[6] WHEREAS, some of these 29 severely overcrowded prisons may even be housing more inmates, because the inmate population continually fluctuates among the CDCR prisons; and

WHEREAS, in addition to the 1,671 incidents of violence perpetrated in these 29 severely overcrowded prisons by inmates against CDCR staff last year, and the 2,642 incidents of violence perpetrated in these prisons on inmates by other inmates in the last year, the suicide rate in these 29 prisons is approaching an average of one per week; and

WHEREAS, the federal court in the Coleman case found mental-health care in CDCR prisons to be below federal constitutional standards due in part to the lack of appropriate beds and space; and

WHEREAS, the use of common areas for inmate housing has severely modified or eliminated certain inmate programs in the 29 prisons with severe overcrowding; and

WHEREAS, the severe overcrowding has also substantially limited or restricted inmate movement, causing significantly reduced inmate attendance in academic, vocational, and rehabilitation programs; and

WHEREAS, overcrowded prisons in other states have experienced some of the deadliest prison riots in American history, including:

In 1971, the nation's deadliest prison riot occurred in Attica, New York, resulting in the death of 43 people. On the day of this riot, the prison — which was built for 1600 — housed approximately 2,300 inmates.

In 1981, a riot occurred in the New Mexico State Penitentiary. More than 30 inmates were killed, more than 100 people were injured, and 12 officers were taken hostage, some of whom were beaten, sexually assaulted, and/or raped. On the day of this riot, the prison — which was built for 900 — housed approximately 1,136 inmates.

In 1993, a riot occurred in Lucasville, Ohio. One officer was murdered, four officers were seriously injured, and nine inmates were killed. On the day of this riot, the prison — which was built for 1600 — housed approximately 2,300 inmates.

WHEREAS, I believe immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding; and

WHEREAS, because of the housing shortage in CDCR prisons, the CDCR has current contracts with four California counties to house 2,352 additional state inmates in local adult jails, but [7] this creates the following overcrowding problem in the county jails:

According to a report by the California State Sheriffs' Association in June 2006, adult jails recently averaged a daily population of approximately 80,000 inmates. On a typical day, the county jails lacked space for more than 4,900 inmates across the state.

Based on the same report, 20 of California's 58 counties have court-imposed population caps resulting from litigation brought by or on behalf of inmates in crowded jails and another 12 counties have self-imposed caps.

Most of California's jail population consists of felony inmates, but when county jails are full, someone in custody must be released before a new inmate can be admitted.

The 2006 Sheriffs' Association report states that last year, 233,388 individuals statewide avoided incarceration or were released early into local communities because of the lack of jail space.

WHEREAS, overcrowding conditions are projected to get even worse in the coming year, to the point that the CDCR expects to run out of all common area space to house prisoners in mid-2007, and will be unable to receive any new inmates; and

WHEREAS, in January 2006, I proposed $6 billion in the Strategic Growth Plan to help manage inmate population at all levels of government by increasing the number of available local jail beds and providing for two new prisons and space for 83,000 prisoners to address California's current and future incarceration needs; and

WHEREAS, the California Legislature failed to act upon this proposal; and

WHEREAS, in March 2006, a proposal was submitted as part of my 2006-07 budget to enable the CDCR to contract for a total of 8,500 beds in community correctional facilities within the state; and

WHEREAS, the California Legislature denied this proposal; and

WHEREAS, on June 26, 2006, I issued a proclamation calling the Legislature into special session because I believed urgent action was needed to address this severe problem in California's prisons, and I wanted to give the Legislature a further opportunity to address this crisis; and

WHEREAS, the CDCR submitted detailed proposals to the Legislature to address the immediate and longer-term needs of the prison system in an effort resolve the overcrowding crisis; and

[8] WHEREAS, the California Legislature failed to adopt the proposals submitted by the CDCR, and also failed to adopt any proposals of its own; and

WHEREAS, in response, my office directed the CDCR to conduct a survey of certain inmates in California's general population to determine how many might voluntarily transfer to out-of-state correctional facilities; and

WHEREAS, the CDCR reports that more than 19,000 inmates expressed interest in voluntarily transferring to a correctional facility outside of California; and

WHEREAS, the overcrowding crisis gets worse with each passing day, creating an emergency in the California prison system.

NOW, THEREFORE, I, ARNOLD SCHWARZENEGGER, Governor of the State of California, in light of the aforementioned, find that conditions of extreme peril to the safety of persons and property exist in the 29 CDCR prisons identified above, due to severe overcrowding, and that the magnitude of the circumstances exceeds the capabilities of the services, personnel, equipment, and facilities of any geographical area in this state. Additionally, the counties within the state are harmed by this situation, as the inability to appropriately house inmates directly impacts local jail capacity and the early release of felons. This crisis spans the eastern, western, northern, and southern parts of the state and compromises the public's safety, and I find that local authority is inadequate to cope with the emergency. Accordingly, under the authority of the California Emergency Services Act, set forth at Title 2, Division 1, Chapter 7 of the California Government Code, commencing with section 8550, I hereby proclaim that a State of Emergency exists within the State of California's prison system.

Pursuant to this proclamation:

I. The CDCR shall, consistent with state law and as deemed appropriate by the CDCR Secretary for the sole purpose of immediately mitigating the severe overcrowding in these 29 prisons and the resulting impacts within California, immediately contract for out-of-state correctional facilities to effectuate voluntary transfers of California prison inmates to facilities outside of this state for incarceration consisting of constitutionally adequate housing, care, and programming.

II. The CDCR Secretary shall, after exhausting all possibilities for voluntary transfers of inmates, and in compliance with the Interstate Corrections Compact and the Western Interstate Corrections Compact, and as he deems necessary and appropriate to mitigate this emergency, effectuate involuntary transfers of California prison inmates, based on criteria set forth below, to institutions in other states and those of the federal government for incarceration consisting of constitutionally adequate housing, care, and programming. In such instance, because strict compliance with California Penal Code sections 11191 and 2911 would prevent, hinder, or delay the mitigation of the severe overcrowding in these prisons, applicable provisions of these statutes are suspended to the extent necessary to enable the CDCR to transfer adult inmates, sentenced under California law, to institutions in other states and those of the federal government without consent. This suspension is limited to the scope and duration of this emergency.

A. The CDCR Secretary shall prioritize for involuntary transfer the inmates who meet the following [9] criteria:

1. Inmates who: (a) have been previously deported by the federal government and are criminal aliens subject to immediate deportation; or (b) have committed an aggravated felony as defined by federal statute and are subject to deportation.

2. Inmates who are paroling outside of California.

3. Inmates who have limited or no family or supportive ties in California based on visitation records and/or other information deemed relevant and appropriate by the CDCR Secretary.

4. Inmates who have family or supportive ties in a transfer state.

5. Other inmates as deemed appropriate by the CDCR Secretary.

B. No person under commitment to the Division of Juvenile Justice may be considered for such transfer.

III. The CDCR Secretary shall, before selecting any inmate for transfer who has individual medical and/or mental-health needs, consult with the court-appointed Receiver of the CDCR medical system and/or the court-assigned Special Master in the *Coleman* mental-health case, depending on the healthcare needs of the inmate, to determine whether a transfer would be appropriate.

IV. The CDCR Secretary shall, before effectuating any inmate transfer, carefully and thoroughly evaluate all appropriate factors, including, but not limited to, the cost-effectiveness of any such transfer and whether an inmate selected for transfer has any pending appeals or hearings that may be impacted by such transfer.

V. The CDCR shall, as deemed appropriate by the CDCR Secretary, contract for facility space, inmate transportation, inmate screening, the services of qualified personnel, and/or for the supplies, materials, equipment, and other services needed to immediately mitigate the severe overcrowding and the resulting impacts within California. Because strict compliance with the provisions of the Government Code and the Public Contract Code applicable to state contracts would prevent, hinder, or delay the mitigation of the severe overcrowding in these prisons, applicable provisions of these statutes, including, but not limited to, advertising and competitive bidding requirements, are suspended to the extent necessary to enable the CDCR to enter into such contracts as expeditiously as possible. This suspension is limited to the scope and duration of this emergency.

I FURTHER DIRECT that as soon as hereafter possible, this proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this proclamation.

[Seal] IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 4th day of October 2006.

ARNOLD SCHWARZENEGGER

Governor of California

[10] ATTEST:

BRUCE McPHERSON

Secretary of State

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California Department of Corrections and Rehabilitation

Expert Panel on Adult Offender Recidivism Reduction Programming

Report to the California State Legislature

[Seal]

Arnold Schwarzenegger
Governor

[Seal]

James E. Tilton
Secretary
California Department of Corrections and Rehabilitation

K.W.Prunty
Undersecretary, Operations
California Department of Corrections and Rehabilitation

Marisela Montes
Chief Deputy Secretary
California Department of Corrections and Rehabilitation

June 2007

* * * *

[vii] Executive Summary

Research shows that correctional programs reduce recidivism by changing offender behavior. However, research also shows that to achieve positive outcomes, correctional agencies must provide rehabilitation programs to the appropriate participants in a manner consistent with evidence-based programming design. California has been offering rehabilitation programs to its adult offenders for over 50 years; yet California's adult offender recidivism rate is one of the highest in the nation. Clearly something is wrong. Either something is preventing the programs from achieving their intended effects or something is wrong with the programs themselves.

The Panel believes that both explanations are true. First, a combination of various factors has caused these programs to be less effective than they should be in reducing criminal behavior. These factors, which must be resolved before California can have any hope of achieving rehabilitation programming success, include dangerous overcrowding (that makes prisons unsafe and reduces space to run programs) and lack of incentives for offenders to participate in rehabilitation programming. Second, the California Department of Corrections and Rehabilitation (CDCR) does not offer enough quality rehabilitation programs to its adult offenders, and it currently assigns offenders to programming in a way that all but ensures that most offenders will not get to the programs they really need.

The Panel

The CDCR created the Expert Panel on Adult Offender Reentry and Recidivism Reduction Programs (the Panel) in response to authorization language placed in the Budget Act of 2006-2007. The Legislature directed the CDCR to contract with correctional program experts to complete an assessment of California's adult prison and parole programs designed to reduce recidivism. Additionally, the CDCR tasked the Panel to provide it with recommendations for improving the programming in California's prison and parole system. This Panel of nationally recognized experts in the field of corrections includes experienced correctional agency administrators and leading academic researchers.

The Roadmap

This Report to the California State Legislature: A Roadmap for Effective Offender Programming in California provides an assessment of the state of correctional programming in California's adult prison and parole systems. This report also includes recommendations intended to guide California in creating a model rehabilitation programming system. The word system is emphasized to underscore the fact that the external environment plays an important role in determining the outcomes of rehabilitation programs. In other words, the activities that occur in the cellblocks, institutional common areas, parole offices, and communities either diminish or enhance the changes offenders make as a result of their rehabilitation programs.

The essential test for each of the Panel's recommendations is: Is it evidence-based? In the Panel's view, "evidence" comes from research and experience. The Panel presents recommendations based on research that represents a broad range of disciplines including rehabilitation, education, corrections administration, psychology, and organizational development. On the experience side, the Panel's recommendations include proposals that within the profession are regarded as best and promising practices and are being used by corrections agencies in other states that have faced situations and challenges similar to California's.

[viii] The target audience of this report is a mixture of policymakers in the legislative and executive branches of California government, as well as practitioners within and outside the CDCR. California's leaders will enhance the value of this report to the extent that they share it with the citizens of California, who are the true stakeholders for what happens in CDCR prisons and parole offices.

External Factors Preventing Programming Success

Beginning in 1976, with the passage of California's Determinate Sentencing Act (DSL), the state began a thirty-year cycle of increasingly stringent "tough on crime" laws. In fact, during this time frame, Californians enacted 80 sentencing laws (Little Hoover Commission, 2007). These laws, like California's "Three Strikes and You're Out" ballot initiative (Proposition 184), resulted in more and more people being sentenced to state prison terms for longer periods of time. In 2005, the California Department of Corrections (CDC) changed its mission to include rehabilitation and was renamed the California Department of Corrections and Rehabilitation (CDCR). But, by that time California's external legal environment had created two significant barriers to the CDCR's internal rehabilitation efforts:

- California's prisons are dangerously overcrowded.
- California treats offenders who complete rehabilitation programs nearly the same way it treats those who do not.

Dangerous Overcrowding

At the time of this report, the CDCR was housing 172,385 prisoners in facilities designed to hold 100,000. The CDCR was housing more than 18,000 of those prisoners in space designed for programming and other activities. The other side of the overcrowding coin is that when wardens implement security lockdowns, they usually shut down all programming in the affected areas. Not only is this disruptive to programming but, the Panel believes the number and duration of lockdowns in California prisons is excessive. (The Panel provides specific space and safety recommendations in Appendix F) In parole offices, space is limited for programming. In some cases this requires the CDCR to offer programming in off-site facilities that are less accessible to parolees and are often crowded themselves.

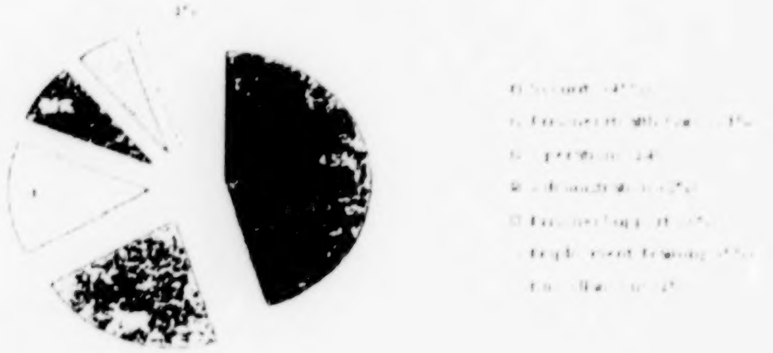
Recommendation 1-Reduce overcrowding in its prison facilities and parole offices.

The Panel recommends that California take the necessary measures to reduce overcrowding in its correctional facilities. Doing so will not solve California's recidivism problems, but it will give its adult offenders the ability to access much-needed rehabilitation programming, which is a "pre-condition" to success.

Lack of Incentives to Complete Programs

The Panel believes that California's correctional culture is oriented more towards control and punishment, than rehabilitation. This has resulted in offenders receiving few incentives to participate in rehabilitation programming. While the Panel agrees that control and safety within prison are essential, it also recognizes that the CDCR needs to balance its custody and rehabilitation missions. Additionally, California needs to reflect this balance in its allocation of correctional resources.

[ix] Figure A: California Annual Costs to Incarcerate a Prisoner



Source: California Legislative Analyst's Office, January 31, 2007

Figure A shows the current imbalance in the CDCR's resource allocations. According to the latest data from the California Legislative Analyst's Office (2007), of the $43,287 that California spends on each prisoner per year, 45% ($19,561) is spent on "Security" concerns, while only 5% ($2,053) is spent on programming ("Employment/Training").

The Panel believes that it is critical for California to institute a system of positive reinforcement of offender behavior that supports rehabilitation. One of the best ways to shape behavior is to provide positive rewards for people when they engage in positive activities. Other states like Pennsylvania, Washington, and Ohio have used such reinforcement systems to encourage positive behavior of offenders in their correctional systems. However, the Panel found that the CDCR does not have a system of sufficient incentives that rewards program completion for all of its programs. Thus the gains that prisoners make in their rehabilitative programming are diluted by a correctional environment that treats offenders who participate in these programs virtually the same as those who do not.

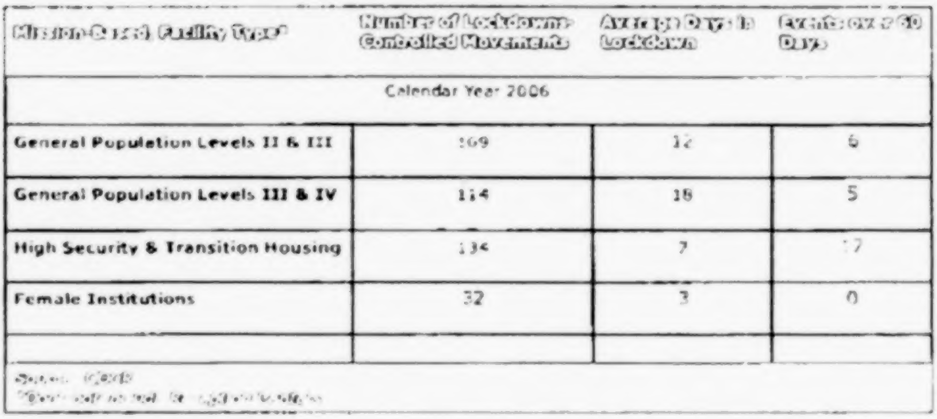
Recommendation 2 Enact legislation to expand its system of positive reinforcements for offenders who successfully complete their rehabilitation] program requirements, comply with institutional rules in prison, and fulfill their parole obligations in the community.

The Panel recommends that California enact the necessary legislation to expand its system of positive reinforcements for program participation and good behavior for offenders in its prison and parole systems. AB 900, which was enacted in May 2007, directed the CDCR to develop incentives for offenders who complete academic and vocational education programs. The Panel believes that further legislation should be enacted that provides incentives for completing any of the evidence-based rehabilitation programs that the CDCR offers to its adult offenders.

Additionally, the Panel recommends that the CDCR implement those positive reinforcements that do not require legislation. For example: expanded visitation privileges, locating prisoners in prisons closer to their homes, providing long distance phone calls, and issuing

* * * *

[10] Table 2: CDCR Adult Institution Lockdown Summary, 2006



Mission-Based Facility Type*	Number of Lockdowns-Controlled Movements	Average Days in Lockdown	Events over 30 Days
Calendar Year 2006			
General Population Levels II & III	169	12	6
General Population Levels III & IV	114	18	5
High Security & Transition Housing	134	7	17
Female Institutions	32	3	0

[illegible]
[illegible]

On the parole side, a legacy of budget and policy decisions has created a situation where parole agents have unmanageable case loads of parolees to supervise and community-based program providers have more offenders needing treatment than they can treat. As Petersilia (2005) has shown, fully two-thirds of more than 120,000 California parolees only see their parole agents once every six weeks. This infrequent visitation schedule causes us to wonder how effective this system is at reducing recidivism.

Recommendation 1-Reduce overcrowding in its prison facilities and parole offices.

We recommend that the CDCR reduce overcrowding in its prison facilities to make it easier for offenders to access rehabilitation programming. This will also create a safer environment for correctional officers, program providers, and prisoners. On the parole side, California needs to either reduce the numbers of parolees to which it provides services or increase the funding to the CDCR Parole Division and community-based program and service providers.

We do not believe the only answer to reducing overcrowding is to build more prisons. Experience from other states demonstrates that at some point those responsible for authorizing and funding adult institutions come to the conclusion that they can no longer afford to keep building more prisons. The expenditures become too costly and can force states to the margins of bankruptcy. With California already spending more than $10 billion a year on its correctional system, we believe that it is only a matter of time before this state is forced to consider alternatives besides prison building to solve its overcrowding problem. Solving the overcrowding problem is not the mission of this Panel. To that end, we direct the reader to Appendix A for specific recommendations provided by other groups as to how California may potentially reduce its correctional system overcrowding. Nonetheless, some of the evidence-based programming recommendations that we make will potentially reduce the numbers of prisoners in California prisons. We provide a detailed discussion in Appendix E.

* * * *

[12] Research by Wright, Caspi, Moffitt, and Paternoster (2004) and Taxman, Soule, and Gelb (1999) determined that punishment, particularly severe punishment, does not deter behavior and that it might actually cause offenders to be more defiant. Defiant offenders do not willingly participate in the rehabilitation programming that they need. According to Andrews and Bonta (1998) to effectively influence behavior there must be a ratio of four rewards to one consequence, since rewards serve to "shape" responses to positive actions.

At the correctional system level, if correctional agencies do not motivate offenders to complete rehabilitation programs, fewer offenders will be willing to participate in those programs. At the program level, those programs that do not have positive reinforcement structures or capacities will not effectively shape offender behaviors.

2a. *Award earned credits to offenders who complete any rehabilitation program in prison and on parole.* While California currently provides earned credits to offenders: (a) who the CDCR assigns to conservation camps to fight fires and perform other public service tasks (the California Work Incentive Program or WIP) and (b) offenders who participate in the Bridging Educational Program, offenders who complete other rehabilitation programs do not receive earned credits. With the enactment of AB 900, we anticipate that the CDCR will soon award earned credits for offenders who complete academic and vocational education programs. We recommend, therefore, that California enact laws that would allow the CDCR to award earned credits to offenders who complete any rehabilitation program, such as substance abuse treatment or life skills development, in accordance with the terms of their behavior management plans. These earned credits would provide motivation for offenders to participate in and successfully complete their assigned rehabilitation programs to earn reduced sentences. Offenders who participate in quality evidence-based prison programming have lower recidivism rates. We believe that the public safety benefits of adopting this recommendation will be a vast improvement over California's current practice of releasing offenders who have not completed rehabilitation programming.

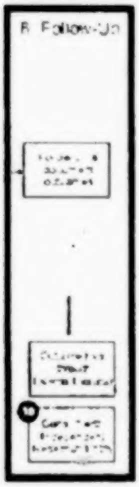
2b. *Replace Work Incentive Program (WIP) credits with statutorily-based good time incentive credits.* Most prisoners in the CDCR are serving sentences that were handed down under California's Determinate Sentencing Act (DSL). California's DSL allows offenders to earn, with some exceptions, as much as a day-for-day "good time" rate (50% reduction), *but only if they are able to receive WIP credits.* While most offenders (with the exception of those serving 3- and 2-Strike sentences, life sentences, and those convicted of violent crimes) are eligible to receive the day-for-day WIP credits, because of program capacity limits, they cannot access the WIP-specific programs. In most cases, offenders are assigned to WIP-specific programs on a first-come, first-served basis, which is contrary to the tenet of assigning the right offender to the right program. We recommend, therefore, that the Legislature pass a law that would allow the CDCR to grant good time credits to those offenders who comply with institutional rules in prison. These good time credits would provide motivation for prisoners to manage their behaviors in prison to earn reduced sentences.

* * * *

[47] *Finding—The CDCR does not have a graduated parole sanctions policy to provide community-based alternatives to incarceration for parolees who violate their parole conditions.*

The ultimate goal of parole supervision is successful completion of parole with no new crimes committed. Compliance with parole conditions is intended to produce reductions in crime by reducing the offender's risk to reoffend. However, there is no evidence to support that the current practice of locking up offenders for technical parole violations (not related to their criminal behavior patterns and/or criminogenic needs) reduces crime. Incarceration is a destabilizing factor for the offender, family, and community, and therefore even short-term interruptions contribute to more negative behaviors in the community,[ab] such as unplanned pregnancies and higher rates of sexually transmitted diseases. Anything that contributes to the removal of individuals from the community has a negative impact, some of which is not measurable. But, Maruna (2001) has shown how difficulties in reintegration are only exacerbated by repeated incarceration periods.

Recommendation 11-Develop structured guidelines to respond to technical parole violations based on risk to reoffend level of the offender and the seriousness of the violation.



[ab] Thomas & Torrone (2006); Rose & Clear (1998); Kubrin & Stewart (2006); Thomas & Sampson (2005); Clear, Rose, Waring, & Scully (2003)

[48] Table 8: Summary of Graduated Responses
Concepts, Relevant Research, and Sanctions

Concept	Relevant Research Findings	Sanction Features
Certainty	Increased perceived certainty of punishment deters future deviance (Grasmick and Bryjak 1980; Paternoster 1989, Nichols and Ross 1990)	Defined Infractions Behavioral contract & Written Notification Structured Sanction Menu
Celerity	Reduction in violations by reducing the interval between violation and sanction (Rhine 1993). Delaying response increases perception that response is unfair or questionable.	Swift Process to Respond
Consistency	Similar decisions made for similar situations increases compliance due to positive experience (Paternoster et al. 1997).	Behavioral contract Structured Sanction Menu
Parsimony	No punishment should be imposed that is more intrusive or restrictive than necessary (Tonry 1996).	Structured Sanction Menu
Proportionality	Level of punishment should be commensurate with severity of the criminal behavior (von Hirsch 1993)	Structured Sanction Menu
Progressiveness	Continued violations result in increasing stringent responses (Altschuler and Armstrong 1994).	Structured Sanction Menu
Neutrality	Responses must be viewed as impartial and consistent with rules, ethics, and logic (Burke 1997).	Defined Infractions Behavioral Contract

11a. Restrict the use of total confinement for parole violations to only certain violations. We recommend that California enact legislation that restricts the use of total confinement (e.g., prison) for technical parole violations to only those violations that are: (a) new felony convictions or (b) technical parole violations that are directly related to the offender's criminal behavior patterns, specific dynamic risk factors, and that also threaten public safety. All other parole violations should result in intermediate, community-based sanctions other than prison.

The most recent data from the US Department of Justice shows that for most states, new prison admissions consists of 71% new felony court convictions and 29% parole violators.[ac] California's new prison admissions, however, consists of 36% new felony court convictions and 64% parole violators, which is nearly the exact opposite of most other states. As mentioned before, part of the disparity between California and other states has to do with the sentencing laws that have been passed in California. For example, in California when a parolee absconds from parole, although it is considered a technical parole violation, state law mandates that serious and violent parolees be referred to the state Board of Parole Hearings (Petersilia, 2006). In 2006, the CDCR admitted nearly 70,000 parole violators to prison. If California were to begin diverting some percentage of less serious (based on an empirical risk assessment) parolees to community-based sanctions instead of prison, it would have less need for prison beds.

[ac] Bureau of Justice Statistics, National Prisoner Statistics Series, August 2, 2000.

[49] Currently in California, sanctions for technical parole violations are determined by three entities: (a) California state law, (b) the California Board of Parole Hearings (BPH), and (c) the CDCR Division of Adult Parole Operations. All three of these entities base their parole violation sanctions on the seriousness of the violation, but not on the risk to reoffend level of the violator. We recommend that California develop and implement structured sanctions-based on seriousness of the violation and offender risk to reoffend-for technical parole violators. The sanctions should address the offenders' criminogenic needs and ensure that offenders are engaged in services and controls appropriate to those needs (Burke, 2000).

11b. Develop a parole sanctions matrix that will provide parole agents with guidelines for determining sanctions for parole violations. The CDCR Division of Adult Parole Operations (DAPO) determines sanctions for approximately 18,000 (24%) of the CDCR's 75,000 total parole violators. Nearly 16,500 of these are non-technical parole violators and the remaining

1,500 are technical parole violators. We recommend that the CDCR create a matrix that incorporates graduated responses in the parole supervision process that support supervision goals and facilitate successful reentry. Having agency guidelines for responding to parole violations serves multiple purposes. Establishing structured parole guidelines will:

- Allow responses to violations to be more fair and consistent throughout the agency, based on a common set of guidelines that provide a set of options appropriate to offender risk level and the seriousness of the violation. While each individual case must be assessed, responses to violations should be viewed as impartial and consistent with rules, ethics, and logic. Similar decisions made for similar situations increases compliance of parolees, whereas dramatically different responses from officer to officer undermine trust and legitimacy of the system.
- Provide parolees with clear supervision expectations and consequences for violations.
- Hold offenders accountable by responding swiftly and certainly to all violations.
- Support maintaining treatment in the community and pro-social activities when feasible.
- Structure efficient use of time, resources, and delegation of authority.
- Allow the delegation of authority and informed decision-making at all levels of the agency.
- Support the agency and staff working together toward a common purpose.

- Facilitate performance measurement and quality assurance.

The graduated responses approach emphasizes using incentives to shape behavior and is based on the concepts in Table 8.

By law, Washington State law does not confine its parole (community custody) violators in prison. Consistent with the principle of just deserts, if parolees commit crimes while on supervision, the state prosecutes them. For non-criminal violations of parole supervision, the Washington DOC created a prescriptive sanctioning grid that specified what punishment was allowed for a range of violations. The grid allows parole officers to return to custody only those high and moderate risk offenders who have committed violations directly related to their criminogenic needs. The WA DOC, through a separate administrative hearing unit, imposes parole sanctions.

* * * *

[77] Appendix A—Reports Previously Published Reports On California's Correctional Crisis

Summary of Previous Reports

We agree with the Little Hoover Commission (2007) in that California doesn't need another report outlining correctional reform measures. What California needs to do is implement some of the proposals that have already been presented to it. Since 1990, there have been more than a dozen reports published that deal with the crisis in California's adult prison system. The major recommendations made in all of these reports are entirely consistent with the recommendations contained in our report. In fact, a review of these 15 reports by Panel co-chair Joan Petersilia revealed that all of the reports recommend essentially the same ten things, which are:

1. Stop sending non-violent, non-serious offenders to prison. This particularly pertains to technical parole violators, who could better be served in community based, intermediate facilities.
2. Once in prison, use a standardized risk and needs assessment tool to match resources with needs and determinate appropriate placements for evidence-based rehabilitation programs.
3. Develop and implement more and better work, education, and substance abuse treatment programs for prisoners and parolees.
4. Reform California's determinate sentencing system to reward prisoners for participating in rehabilitation programs and allow the system to retain prisoners who represent a continued public safety risk.
5. Move low risk prisoners to community-based facilities toward the later part of their sentences to foster successful reintegration and save more expensive prison-based resources. Subpopulations, such as women, the elderly and the sick, are ideal candidates.
6. Create a sentencing policy commission or some other administrative body that is authorized to design new sentencing statutes into a workable system that balances uniformity of sentencing with flexibility of individualization.

7. Reform California's parole system so that non-serious parole violators are handled in community

based intermediate facilities and more violent parole violators are prosecuted for new crimes.

8. Create viable partnerships between state and local corrections agencies that would expand sentencing options, enhance rehabilitation services, and strengthen local reentry systems. Suggestions have been made that include Community Corrections Acts (to get greater funding for local criminal justice initiatives) and a Community Corrections Division of the CDCR charged with developing alternatives.
9. Evaluate all programs and require that existing and newly funded programs are based on solid research evidence.
10. Promote public awareness so that taxpayers know what they are getting for their public safety investment and become smarter and more engaged about California's prison system.

[78] List of Previous Reports

Blue Ribbon Commission on Inmate Population Management (1990) established by the California legislature in 1987, chaired by Grover Trask (District Attorney Riverside County. It issued its final report in 1990 with 38 recommendations. Recommended alternative sanctions, and more programming, reentry programs.

Prison Population and Criminal Justice Policy in California (1992). California Policy Seminar. Frank Zimring and Gordon Hawkins. Analysis of the recent expansion of California prisons and alternative policy responses.

Crime and Punishment in California: Full Cells, Empty Pockets, and Questionable Benefits (1993).

California Policy Research Center, Joan Petersilia describes the growing problem of parole violators in California prisons.

Putting Violence Behind Bars: Redefining the Role of California's Prisons (1994). The Little Hoover Commission found that the State's sentencing system was unduly complicated and inequitable to both victims and offenders and there was little distinction between the way violent and non-violent criminals were handled. The Commission recommended that the State create a sentencing commission to develop a sentencing structure that protects public safety, tailors the punishment to fit the crime, addresses the needs of victims, fosters responsibility in prisoners and balances costs with benefits.

Estimating the Effect of Increased Incarceration on Crime in California (1995). California Policy Research Center, Franklin Zimring and his authors describe the impact of increased prison populations on crime rates in California.

Minimizing Harm as a Goal for Crime Policy in California (1997). California Policy Seminar Report. Edited by Edward Rubin, with analysis and chapters by Zimring, Greenwood, Petersilia, Skolnick, and others. Purpose was to draw on the work of leading criminologists to consider ways to address the critical problems facing California criminal justice system.

Beyond Bars: Correctional Reforms to Lower Prison Costs and Reduce Crime (1998). The Little Hoover Commission found that state and local correctional systems were not integrated and that the State's response to offenders needed to include an expansion of local sanctions and community correctional facilities for low-level offenders. The Commission also recommended expanding programs for prisoners and parolees, developing separate facilities for parolees returned to custody who are most likely to re-offend and re-evaluating the organizational structure of parole.

Challenges of Prisoner Reentry and Parole in California (2000). Joan Petersilia, California Policy Research Center. Describes the unique challenges of California's prisoner reentry problem.

Back to the Community: Safe and Sound Parole Policies (2003). Little Hoover Commission found that the State's parole policies resulted in far too many parolees returning to overcrowded prison facilities for technical violations. The Commission proposed expanding evidence-based rehabilitative programs for prisoners and parolees and recommended policymakers review the sentencing laws that place every offender on parole following incarceration.

Breaking the Barriers for Women on Parole (2004). The Little Hoover Commission studied the unique barriers facing the more than 10,000 women in California's prisons and 12,000 women on parole.

[79] *Governor's Plan to Reorganize the Youth and Adult Correctional Agency* (2005). Corrections Independent Review Panel: Reforming California's Youth and Adult Correctional System ("The Deukmejian Report"). The Commission reviewed Governor Schwarzenegger's plan to reorganize the Youth and Adult Correctional Agency into the Department of Corrections and Rehabilitation. This reorganization, which the Commission supported, placed a renewed emphasis on rehabilitation for prisoners and parolees.

Understanding California Corrections, California Policy Research Center (2006). Joan Petersilia wrote a primer on the California corrections system, from arrest through release on parole and return. She recommended greater emphasis on in-prison and parole planning, presumptive sentencing or a sentencing commission, and a return to indeterminate sentencing.

Task Force on California Prison Crowding, National Council on Crime and Delinquency (2006). This report offers policy and program options to address the severe problems in California prisons.

Reducing the Incarceration of Women: Community Based Alternatives, National Council on Crime and Delinquency (2006).This report describes effective treatment for women in prison in California.

Solving California's Corrections Crisis: Time is Running Out (2007). The Little Hoover Commission studied the correctional crisis facing California from a financial expenditure perspective.

* * * *

[87] Appendix E—Estimating the Impacts of Our Recommendations

In this section of the report, we present the impact of our recommendations from three perspectives: (a) recidivism reduction, (b) prison and parole population reductions, and (c) financial costs and benefits associated with recidivism and correctional population reductions.

None of the recommendations made by the Panel will have any impact on the number of persons being sentenced by the courts to the CDCR or their sentence lengths. Rather our recommendations will only affect the large numbers of persons who are being returned to custody for violating their parole conditions and the amounts of time served in prison or on parole.

Our estimates are grounded in a large number of studies and the experiences of other states that have successfully implemented such reforms without adversely impacting public safety. However, we emphasize that the major recommendations require legislative, administrative, and programmatic changes before California can implement them.

The legislature, with the consent of the governor, must modify California's current sentencing laws, which affects how much good time prisoners receive. We are mindful that this may be more difficult to do for offenders sentenced under the state's two and three strikes laws, so we have separated our recommendations accordingly.

The CDCR must enact new administrative policies that reasonably restrict the large number of parolees being returned to prison for technical violations, This has been done before in California and is being done in other states. Finally, the CDCR, with proper funding from the legislature, will need to make significant changes in the number and types of programs it offers to prisoners and parolees. Ineffective programs that hold little, if any, promise of reducing recidivism need to be identified and de-funded as quickly as possible. Then, new and effective programs need to be created. For this to occur, the CDCR will need to re-organize its own operational capabilities as outlined in Appendix J.

It is important to note that these estimates are based on the data that were made available to the

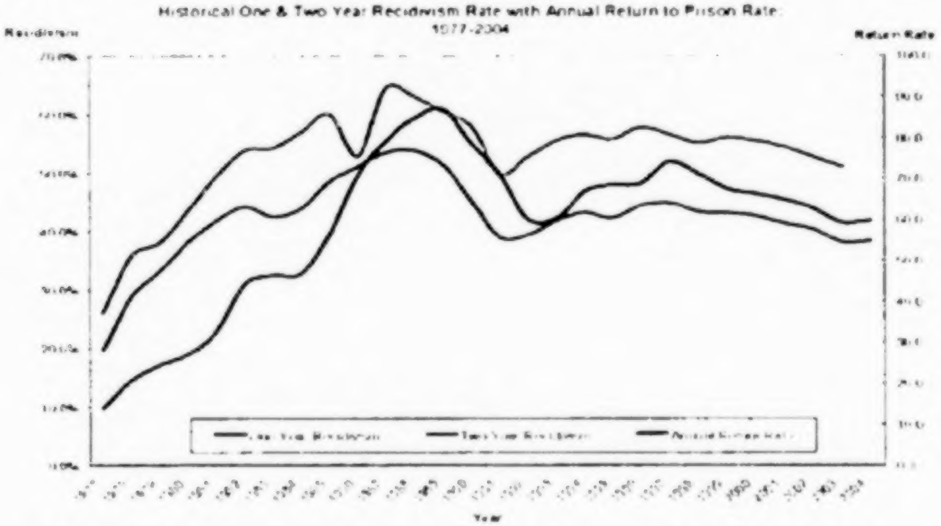
Panel by the CDCR as well as the experiences of the other state correctional systems. As such they are preliminary in nature and subject to modification based on further analysis that may be required. Once it becomes clear on the extent to which the recommendations will be adopted and implemented more precise estimates should be made. It is also important to note that the CDCR has neither authenticated nor endorsed our estimates.

Nonetheless, we believe that if California were to implement our recommendations, the state may significantly reduce the large number of parolees who are currently violating their parole conditions and being returned to prison. Further, by expanding its incentive system, the state will encourage prisoners and parolees to participate in and complete programs. This could lower California's projected prison population with no major increase to the parole population. Coupled with the appropriate investments in prison and community based programming, we believe that our plan would increase public safety, reduce crime, and save taxpayer dollars.

Impact on Recidivism

One of the key objectives of the Panel's recommendations is to lower the CDCR's high recidivism rate. Recidivism rates are typically measured by tracking a cohort of prisoners [88] who were released in a given year and following them for several years. Traditionally, a recidivism rate is based on a three year follow-up period. The three measures of recidivism are (a) re-arrest, (b) reconviction, or c) a return to the prison system for either a new court conviction or a parole violation. California's recidivism rate as measured by the return to prison rate is one of highest in the nation (only Utah has a higher rate). However, this high rate reflects the California Board of Prison Term's and the CDCR's policy of returning to prison a large proportion of parolees that have been revoked for technical violations.[af]

Figure E-1: California Department of Corrections Historical Recidivism Rates, 1977-2004[ag]



California's return to prison recidivism rate was not always this high. As shown in Figure E-1, beginning in the late 1970s the CDCR's recidivism rate was much lower (below 30%). What is responsible for the dramatic increase? No single cause can be identified but contributing factors may include: (a) the passage of California's Determinate Sentencing Law

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[af] Petersilia (2006); Jacobson (2003); US Department of Justice, Bureau of Justice Statistics (2001).

[ag] The recidivism rate shown in this chart is based on "first releases to parole." This means that the cohort consists of prisoners who were experiencing their first release to parole and does not include parole violators who were being re-released. Excluding parole violators decreases the overall return-to-prison rate.

(DSL) in 1977, which eliminated discretionary parole statutorily awarded good time credits, (b) the massive expansion of the CDCR population, and (c) the associated construction of "mega prisons"—large facilities designed to house several thousand prisoners. We believe that while it may not be possible to quickly or easily return to the recidivism rates of the late 1970's, it is possible to achieve significant reductions in the current return to prison rate.

[89] Three of our recommendations deal directly with recidivism reduction strategies:

11a. *Restrict the use of total confinement for parole violations to only certain violations.* The largest reduction in the return to prison rate would occur if the state adopts the recommendation to divert between 44% and 64% of the parolees who are now being returned to prison for non felony criminal behavior and technical violations (see Table E-1). The CDCR could achieve this by developing and implementing a system of graduated responses to parole violations which provides for swift and certain punishments in the community.

These reductions in technical violations may seem large to some, yet if accomplished, it would result in California approaching the same percentage of parolees being returned to prison as reported by other states for either a technical or new felony. The most recent data from the US Department of Justice shows that 27% of all admissions to prison consist of parole violators (either technical or new felony crime).

Table E-1: Technical Parole Violator Diversion Estimates by Type of Return Based on 2006 Admissions

Type of Return	Number of Total	Number to be diverted at low end of range	Number to be diverted at high end of range
Those returned to custody but re-released to parole; We estimate that 80 to 100 percent should be diverted.	12,463 (18%)	9,970	**12,463**
Type I Administrative Criminal Returns (least serious crimes); We estimate that 40 to 60 percent should be diverted.	16,617 (24%	6,647	**9,970**
Type II Administrative Criminal Returns (crimes of average seriousness); We estimate that 25 to 45 percent should be diverted.	16,617 (24%)	4,154	**7,478**
Type III Administrative Criminal Returns (most serious crimes); We estimate that 15 to 35 percent should be diverted	9,693 (14%)	1,454	**3,393**
Administrative Non Criminal Returns; We estimate that 65 to 85 percent should be diverted.	13,155 (19%	8,551	**11,182**
Total Parole Violators Diverted from Return To Prison		**30,776 (44%)**	**44,485 (64%)**

If California were to divert approximately 35,000 technical violators from re-imprisonment within the CDCR, total admissions would drop from approximately 142,000 to 107,000 (see Table E-2).

But even this reduction would not match the norm of other state prison systems. The third column of Table E-2 shows that if the CDCR were to have the same policies as other states, the total number of admissions would decline to approximately 71,000. This estimate assumes that 40% of the offenders admitted to prison would return after being released on parole (the same rate reported by BJS minus California's data). As shown in Table E-2, were California to reach the national recidivism average, the percent of admissions to prison who are parole violators would be reduced to approximately 20,000 or 29% of all admissions-which is virtually the same as the national rate (27%). We believe that this is a very achievable outcome given the experience of the other states.

[90] Table E-2 Estimated Impact of Recommendation 9a on Prison Admissions by Type of Admission

	Current		Recommended		Based on Other States[a]	
Admissions Type	N	%	N	%	N	%
Felony Court	50,708	35%	50,708	47%	50,708	71%
Parole Violators	91,173	64%	56,555	53%	20,283	29%
Technical	69,237	49%	35,619	32%	10,142	14%
New Felony	21,936	15%	21,936	20%	10,142	14%
Total	**141,881**	**100%**	**107,263**	**100%**	**70,991**	**100%**

[a] Based on all states reporting to the Bureau of Justice Statistics, National Prisoner Statistics Series, August 8, 2000

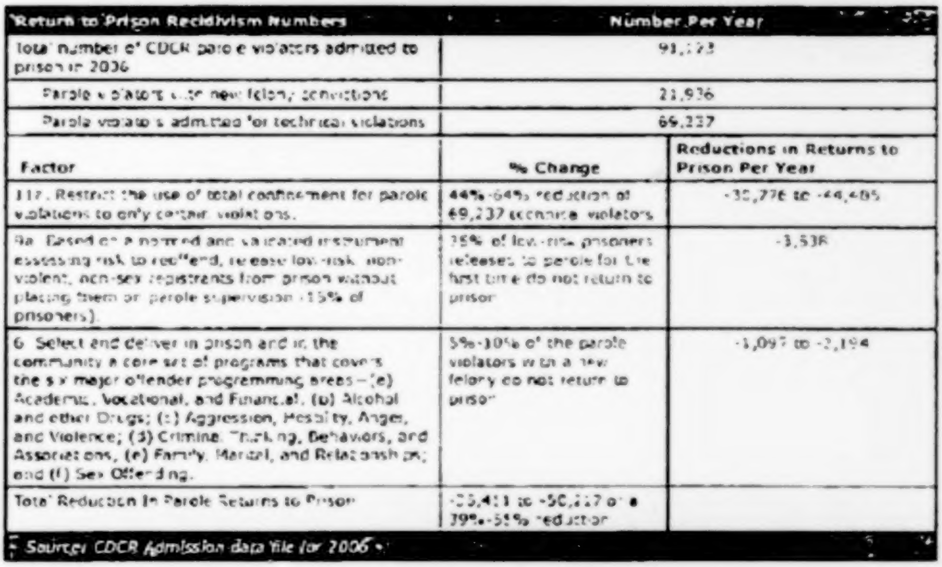
9a. Based on a normed and validated instrument assessing risk to reoffend, release low-risk, non-violent, non-sex registrants from prison without placing them on parole supervision. The second way to reduce returns to prison is to not supervise low risk parolees. Previous studies have shown that imposing parole and probation supervision conditions on those who are unlikely to recidivate serves to actually increase recidivism rates. Table E-2 shows the results of several studies of the relatively effects of supervision on offenders by risk level. Here one can see that supervised low risk offenders have higher recidivism rates. By not supervising them the recidivism rates will actually decrease.

6. *Select and deliver in prison and in the community a core set of programs that covers the six major offender programming areas-(a) Academic, Vocational, and Financial; (b) Alcohol and other Drugs; (c) Aggression, Hostility, Anger, and Violence; (d) Criminal Thinking, Behaviors, and Associations; (e) Family, Marital, and Relationships; and (f) Sex Offending.* The third way for California to reduce its recidivism rate is by offering prisoners and parolees programs that will address and treat their educational, vocational training, mental health, and related criminogenic needs. As offenders receive programming that

addresses theses needs, there should be a modest but significant reduction in their criminal behavior.

Table E-3 summarizes the expected return to prison recidivism reductions for each of these three major recommendations. This table is based on the total number of persons who were admitted to the CDCR in 2006 for failing parole for either a new felony conviction or a technical violation. As suggested previously, the largest reduction in the 91,173 now being returned back to prison each year would be persons who have failed parole for technical violations (a reduction of 30,776 to 44,485). In total, the recommendations would reduce the total number of returns to prison by between 35,000 and 50,000 or approximately 39-55%.

[91] Table E-3 Estimated Impact of Recommendations of Released Prisoners Being Returned to Prison



Return to Prison Recidivism Numbers	Number Per Year	
Total number of CDCR parole violators admitted to prison in 2006	91,173	
Parole violators with new felony convictions	21,936	
Parole violators admitted for technical violations	69,237	
Factor	**% Change**	**Reductions in Returns to Prison Per Year**
11. Restrict the use of total confinement for parole violations to only certain violations.	44%-64% reduction of 69,237 technical violators	-30,776 to -44,485
9a. Based on a normed and validated instrument assessing risk to reoffend, release low-risk, non-violent, non-sex registrants from prison without placing them on parole supervision (15% of prisoners).	35% of low-risk prisoners released to parole for the first time do not return to prison	-3,538
6. Select and deliver in prison and in the community a core set of programs that covers the six major offender programming areas – (a) Academic, Vocational, and Financial; (b) Alcohol and other Drugs; (c) Aggression, Hostility, Anger, and Violence; (d) Criminal Thinking, Behaviors, and Associations; (e) Family, Marital, and Relationships; and (f) Sex Offending.	5%-10% of the parole violators with a new felony do not return to prison	-1,097 to -2,194
Total Reduction in Parole Returns to Prison	-35,411 to -50,217 or a 39%-55% reduction	

Source: CDCR Admission data file for 2006

Impact on Prison and Parole Populations

There are three operational requirements for successful offender programming: (a) adequate program space for the programs to function, (b) the physical locations where the programs are being delivered must be safe, and (c) there must be incentives for offenders to participate. Few of these conditions exist currently within the CDCR.[ah] Space-wise, although we don't have the precise figures, we know that because of overcrowding, designated program spaces have been converted to housing units. From a safety standpoint, there is growing evidence of increased violence and disruptive behavior within the CDCR—the rate of serious incidents increased from 4.7 per 100 prisoners in 1990, to 7.9 per 100 prisoners in 2005 (CDCR, 2006). And in the area of incentives, with California's DSL, there are few incentives for prisoners to participate in meaningful programs as they know that they will be released at the same time as prisoners who do not participate.

In Appendix L, we provided information concerning the CDCR's current population. It should be noted that the CDCR latest projections estimate that by the year 2012, the CDCR's prison population will increase from 172,385 to 190,000, and its parole population from 123,781 to 133,000.

We developed our own estimates of the impacts of our recommendations on the CDCR prison and parole populations. We based these estimates on data provided by the CDCR on admissions and releases for the prison and parole systems. Our estimates only assume a "steady state" environment and do not indicate how our recommendations would impact future sized populations. Again, we note that the CDCR has neither authenticated nor endorsed our estimates.

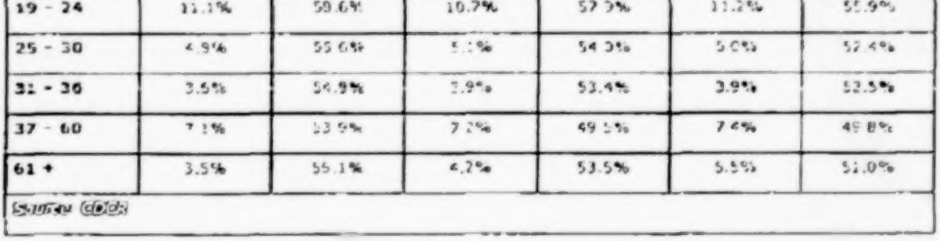
[ah] There are some individual facilities that are successfully delivering effective programs, however, systemically, the CDCR has to resolve its issues with space, safety, and incentives.

[92] We believe that if all of our recommendations are adopted, the current prison population would be reduced by approximately 41,000 to 48,000 prisoners and the number of admissions to prison for all parole violators (including new felonies) will be reduced by between 35,000 and 50,000 parolees. We believe that there are three recommendations that deal directly with reducing the offender populations:

2. *Enact legislation to expand its system of positive reinforcements for offenders who successfully complete their rehabilitation program requirements, comply with institutional rules in prison, and fulfill their parole obligations in the community*. The three sub-recommendations of this recommendation must be applied to have the desired population reduction effect. We also note that each component will require new legislation that would modify the current California Penal Code (CPC).

2a. *Award earned credits to offenders who complete any rehabilitation program in prison and on parole*. This recommendation would allow prisoners who complete education, vocational training, and substance abuse treatment programs the opportunity to receive an average of four months off of their prison release dates (including all sentenced felons regardless of their offense or strike levels). It would encourage prisoners (who could benefit) to participate in well-structured and effective rehabilitative programs and thus help lower their reoffending rates. At the same time, prisoners who complete these programs would benefit by having their period of imprisonment reduced. Virtually all of the other states plus the Federal prison system allow for prison terms to be reduced if a prisoner completes rehabilitative services. Further it has been widely established by a number of studies, including those conducted by the US Department of Justice and the CDCR, there is no relationship between time served and recidivism (US Department of Justice, 2006). Therefore, releasing prisoners early as a result of earning program credits will not increase their recidivism rates. In fact, because they will have participated in effective programming targeted to reduce their criminogenic needs factors, we expect their recidivism rates to decrease. Table E-4 demonstrates the relationship between length of stay and recidivism using CDCR data.

Table E-4 CDCR Recidivism Rates for First Releases by Time Served, 2000-2002
Time Served Release Year



Time Served	Release Year					
	2000		2001		2002	
Total	100.0%	63.6%	100.0%	59.4%	100.0%	57.3%
0 - 6	15.9%	66.0%	16.7%	63.5%	17.6%	61.9%
7 - 12	37.0%	62.6%	35.5%	62.7%	33.1%	60.1%
13 - 18	16.9%	59.0%	16.6%	57.2%	16.3%	55.7%
19 - 24	11.1%	59.6%	10.7%	57.3%	11.2%	55.9%
25 - 30	4.9%	55.6%	5.1%	54.3%	5.0%	52.4%
31 - 36	3.5%	54.9%	3.9%	53.4%	3.9%	52.5%
37 - 60	7.1%	53.9%	7.2%	49.5%	7.4%	49.8%
61 +	3.5%	55.1%	4.2%	53.5%	5.5%	51.0%
Source: CDCR						

[93] *Impact: Based on an assumption that 50,000 to 56,000 prisoners of a release cohort would complete such a program and receive an average*

four-month award, the number of beds saved would be approximately 17,000 to 19,000.[iii]

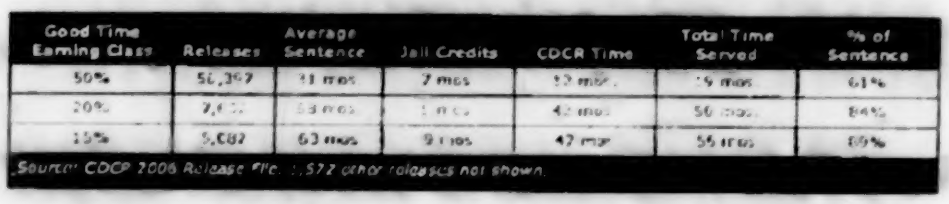
2b. *Replace Work Incentive Program (WIP) credits with statutorily-based good time incentive credits.* This recommendation would allow offenders to earn good time credits based upon statute, rather than program participation. This would provide more equity and certainty to the punishment being handed out by the courts. Table E-5 shows the numbers of prisoners who are statutorily eligible for day-for-day ("good time") credits and the percentage of their sentences that they are actually serving. Here one can see that on average, prisoners eligible for day-for-day work incentive credits are actually serving over 60% of their sentences when jail credits (the amount time spent in local jails awaiting the disposition of their case(s) and transfers to the CDCR) are added to the calculations (see Table E-5).

If they were receiving day-for-day, their time served in prison would be reduced by a modest 2-4 months. And since Table E-4 shows that there is no relationship between length of stay (at far greater amounts) and recidivism we know this policy would not adversely impact public safety. This conclusion is further buttressed by a large number of studies showing no relationship between length of stay and recidivism rates (NCCD, 2007).

Many other states allow prisoners to receive day-for-day credits statutorily, rather than based on participation in some type of program or work assignment. Indeed before the passage of DSL, California's laws allowed all prisoners to be eligible for parole at 1/3rd of their sentences thru the application of statutory credits. Returning back to that concept would provide more equity and certainty to the punishment being handed out by the courts.

[iii] Table E-7 shows that between 55,000 and 62,000 offenders would be eligible for in-prison programming in a given year. Assuming that 10% (5,500 to 6,200) fail to complete the program, we estimate that approximately 50,000 to 56,000 offenders successfully complete programs.

Table E-5: Percent Time Served For New Court Commitments and Parole Violators with New Terms Only Eligible for Day-for-Day Credits 2006 Releases



Good Time Earning Class	Releases	Average Sentence	Jail Credits	CDCR Time	Total Time Served	% of Sentence
50%	56,3[illegible]7	31 mos	7 mos	12 mos	19 mos	61%
20%	7,[illegible]	5[illegible] mos	[illegible] mos	42 mos	50 mos	84%
15%	5,082	63 mos	9 mos	47 mos	56 mos	89%

Source: CDCR 2006 Release File. 1,572 other releases not shown.

Impact: Assuming that those prisoners now eligible for the WIP day for day credits were to receive them statutorily, the number of prison beds saved would be approximately 14,000. This estimate takes into account the amount of good time that is being revoked by the CDCR for rules infractions. The effects would be even greater if prisoners in the 20% and 15% earning classes who have much longer sentences were to be eligible for the 50% class. Specifically if the 20% earning class was modified to 50%, the long term effects would be approximately 13,000 bed reduction. If applied to the 15% earning class, the bed savings would be approximately 10,000. So if applied to all prisoners, the net effect would be about 37,000 in bed savings.

[94] 2c. *Implement an earned discharge parole supervision strategy for all parolees released from prison after serving a period of incarceration for an offense other than those listed as serious and violent*

under CPC 1192.7(c) and 667.5(c) criteria. This recommendation would serve to reduce the time parolees spend on parole supervision based on good conduct and-or program participation. If the recommendations 6a and 6b are implemented, it is likely that the parole population will significantly increase unless similar efforts are enacted to reduce the time served on parole and-or successful parole completion rates are increased. The California legislature recently introduced several bills that would make such reductions possible. For example, Senate Bill 1453 would reduce the period of supervision by six months when a parolee completes a substance abuse program while on supervision. It is estimated that 5,250 parolees would be impacted by this bill, which would reduce the parole population by 2,500. Our recommendation builds upon these bills.

> *Impact: Since these reforms are tied to yet unknown risk levels of the parole population as well as their capacity to meet the behavioral standards, it is not possible to make a precise impact estimate. However, we believe that the parole population would be reduced by approximately 29,000 parolees, based on the assumptions that:*
>
> - *about 85% of the 67,000 prisoners being admitted to parole for their first release will be in the moderate to high risk to reoffend category (an estimated 57,000 first parole admissions), and*
> - *that at least 50% of them (28,500) will meet the threshold for having their periods of parole supervision reduced by at least a year.*

9a. Based on a normed and validated instrument assessing risk to reoffend, release low-risk, non-

violent, non-sex registrants from prison without placing them on parole supervision. This recommendation would simply eliminate supervision for low risk parolees.

Impact: We believe that approximately 875 prison beds would be saved, based on the assumptions that:

- *approximately 15% of the 67,000 first-time admissions to parole being reinstated or re-released are low risk (an estimated 10,000 parolees), and*
- *35% of them (approximately 3,500) are being returned for technical violations for which they return to prison for approximately 3 months.*

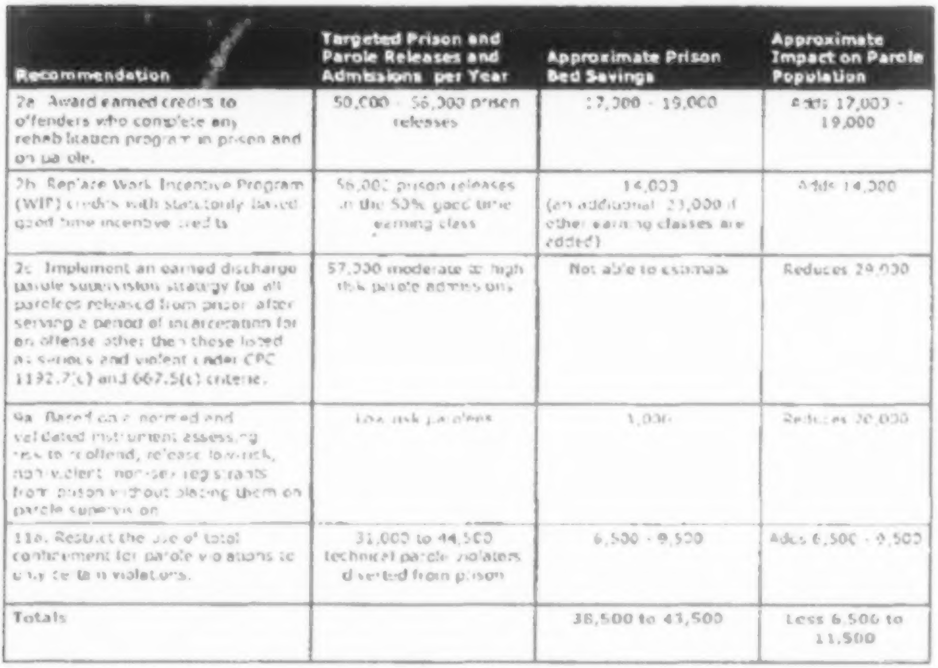
More importantly, the projected parole population would decline by approximately 20,000 assuming these low risk parolees currently are being supervised for an average of 2 years.

11a. Restrict the use of total confinement for parole violations to only certain violations. The large numbers of technical violators returned each year represents an ineffective approach to managing noncompliant behavior on the part of CDCR parolees. While we do not expect to completely turn off the technical violation stream without a statutory prohibition, as was done in Washington State, we do believe it reasonable and desirable to considerably reduce the current rate by establishing new policies and implementing an array of graduated parole violation sanctions. By diverting these prisoners from supervision, fewer be returned to prison for technical violations.

> *Impact: Based on an assumption that over a two year period there will be a 44-64% reduction in the return rate for technical violations, the number of persons admitted to the CDCR for technical violations would decline from 69,000 to between 25,000 and 38,500. Of those diverted, 10,000-12,500 would only have been returned to the CDCR for 2 weeks and then re-released to parole. The number of prison beds saved for this group would be approximately 500 beds. For the remainder, based on their [95] current average length of stay of three months, the number of prison beds saved would range from approximately 6,500 to 9,500.*

Table E-6 provides a summary of our population reduction impacts. In total the current CDCR prisoner population would be reduced by between 38,500 and 43,500 prisoners-largely by establishing a programs incentive system along the lines adopted by other state prison systems. The parole population would be reduced by between 6,500 and 11,500.

Table E-6: Summary of Population Reduction Impacts Rounded to Nearest 500



Recommendation	Targeted Prison and Parole Releases and Admissions per Year	Approximate Prison Bed Savings	Approximate Impact on Parole Population
2a. Award earned credits to offenders who complete any rehabilitation program in prison and on parole.	50,000 - 56,000 prison releases	17,000 - 19,000	Adds 17,000 - 19,000
2b. Replace Work Incentive Program (WIP) credits with statutorily based good time incentive credits	56,000 prison releases in the 50% good time earning class	14,000 (an additional 23,000 if other earning classes are added)	Adds 14,000
2c. Implement an earned discharge parole supervision strategy for all parolees released from prison after serving a period of incarceration for an offense other than those listed as serious and violent under CPC 1192.7(c) and 667.5(c) criteria.	57,000 moderate to high risk parole admissions	Not able to estimate	Reduces 29,000
9a. Based on a normed and validated instrument assessing risk to re-offend, release low-risk, non-violent, non-sex registrants from prison without placing them on parole supervision	Low risk parolees	1,000	Reduces 20,000
11a. Restrict the use of total confinement for parole violations to only certain violators.	31,000 to 44,500 technical parole violators diverted from prison	6,500 - 9,500	Adds 6,500 - 9,500
Totals		38,500 to 43,500	Less 6,500 to 11,500

How quickly California can achieve these reductions will depend upon a number of options available to the state. If the legislature makes the necessary changes in good time laws for the non-two and three strike prisoners retroactive to all prisoners currently incarcerated, most of the effects would occur within two years. Similarly, if the CDCR were to make administrative changes in its policies toward parole violators, most of the effects would be realized within two years. Changes based on additional and more effective treatment will take many years to realize. It will take several years to develop proper risk assessment systems, start assigning prisoners by risk, and ramp up the needed programs.

* * * *

[101] Appendix F—Expanded Space and Safety Recommendations

This section of the report contains the Panel's detailed recommendations concerning the physical context of CDCR programming.

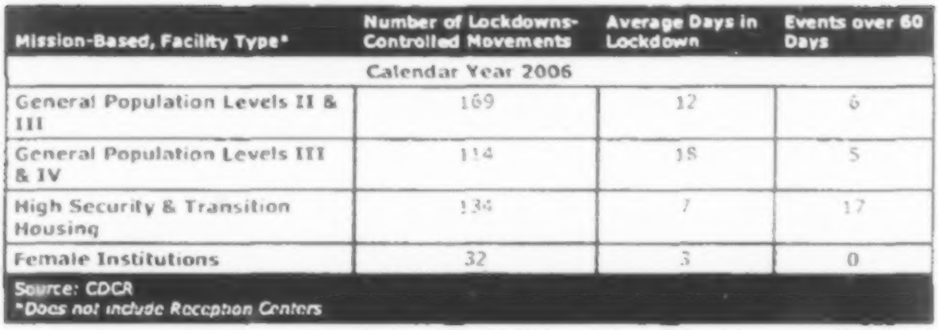
Program Space Concerns

The largest barrier that the Panel identified to delivering effective programming in CDCR prison facilities is its current state of overcrowding. CDCR facilities were built to hold 100,000 offenders; however, at the time of this report, the CDCR was currently housing 172,385 offenders in its prisons. Because of this overcrowding situation, there is simply not enough space to conduct effective programming-this applies to both the male and female offender populations. Due to time and budget constraints, we were unable to obtain data concerning specific details as to how the CDCR is utilizing its designated program spaces, although we suspect that some of them are being used to house offenders.

Physical Safety Concerns

The CDCR tracks the number of prisoner population lockdowns and controlled movement events by each institution. The degree to which the CDCR quickly re-opens the affected facility within an institution to allow prisoner access to programming or allows the non-involved prisoners to attend programs, will impact its ability to support effective program delivery.

Table E-1: CDCR Adult Institution
Lockdown Summary, 2006



Mission-Based, Facility Type*	Number of Lockdowns-Controlled Movements	Average Days in Lockdown	Events over 60 Days
Calendar Year 2006			
General Population Levels II & III	169	12	6
General Population Levels III & IV	114	18	5
High Security & Transition Housing	134	7	17
Female Institutions	32	3	0

Source: CDCR
*Does not include Reception Centers

Table E-1 provides data concerning the number of lockdown days during 2006, among the 33 adult prison institutions (except Reception Centers).

The frequency and duration of lockdowns and controlled movement at any given time, among the 33 institutions, is a daily challenge to the CDCR, and one which most California citizens are unaware. Institution or facility lockdowns (or controlled movements of prisoners) occur when serious incidents happen that require additional levels of control. The employees who deliver programming to the prisoners are present five days a week, eight hours each day, with some down time for program audits, training, and program adjustments. The security protocols that the CDCR applies immediately after a serious incident within an institution, in an attempt to ensure safety to prisoners, staff, and the public, causes the prisoners to be absent from their assigned program areas, and away from the program staff. The overcrowding conditions also contribute to the challenge handled by those employees who are ready and able to deliver programming to the prisoners, that is, not enough program space and not enough employees to deliver essential programs to meet [102] the needs of the prisoners.

The CDCR should continue its progress in reviewing its lockdown and lockdown lifting protocols, and its controlled movement protocols, at each institution to determine the extent to which prisoner programming can be safely and quickly resumed following a serious incident. This periodic review is a good security practice and supports the ever-changing types of prisoners being housed in a facility within an institution. Where lockdowns are prolonged, CDCR should expect staff to develop alternate delivery methods of programming to housing areas, without serious detriment to program fidelity and without serious interference with security needs.

Recommendations

In addition to what we have already stated, we offer these recommendations, which are based primarily on the fact the CDCR is overcrowded and violence and safety issues are related to overcrowding in any system. These recommendations are also based on comments from CDCR staff members whom we interviewed who shared with us their perspectives about the negative effect that lockdowns were having on programming in their facilities. *For staff to be able to appropriately deliver programs and for offenders to be able to fully benefit from them, adequate and safe spaces for programming must be created.* The CDCR must take steps to reduce the overcrowding in its facilities. If this does not occur, the positive impact of increased and/or more focused programming will be adversely affected.

While it is reducing its overcrowding, there are additional steps the CDCR can and should take to improve staff and offender safety.

First, the CDCR should review assaults, disturbances, and lockdowns by facility to determine which facilities offer a safe environment and which are problematic. Those facilities that the CDCR deems to be safe should be the first facilities where it implements new or improved programs. Those facilities that the CDCR deems to be problematic should be reviewed to determine what steps need to be taken to improve safety in those locations. As those facilities improve their safety levels, the CDCR should implement programming in those facilities that enhances those safety improvements.

Second, experience shows that drugs are often the source of disorder within facilities. Experience at the Pennsylvania Department of Corrections demonstrates that it is possible with the implementation of a comprehensive drug interdiction program to reduce the random positive rate to less than 1%. Such a program would include interdiction (dogs, drug detection devices, and searches of vehicles and everyone who enters the facility); facility searches (cells and common areas); regular random and target drug tests; penalties (loss of contact visiting, loss of visits, and banning from facilities); treatment for those with drug problems; and tracking of various outcome measures. In this regard it must be remembered that visits are the most frequent sources of contraband entering facilities. Most states search visitors and use cameras in visiting areas to attempt to stem the flow of drugs and other contraband into their prisons. Additionally, while it is unfortunate that a few staff get involved in bringing contraband into facilities, it is critical for the safety of all concerned that the CDCR implement measures to limit this potential additional avenue for drugs to enter its system. Regular use of metal detectors on everyone (including staff), random staff pat searches, and use of electronic drug detection devices must be a part of any overall safety program.

[103] Third, the CDCR should begin to use walk-through and hand-held metal detectors throughout its facilities. These tools can aid significantly in reducing the amount of weapons used by offenders. The CDCR can set up stations for these valuable tools at entrances to yards, cell blocks, and work areas.

Fourth, the CDCR should develop a vulnerability analysis (VA) program similar to what is used by the Pennsylvania Department of Corrections. The VA program involves training staff members to routinely assess institutions on a variety of security measures. Trained staff members from other institutions conduct the assessment, which differs from a normal review of policy compliance, in that they actually performance test various security systems. This activity, coupled with a policy that requires ongoing complacency drills that test such things as escapes, contraband introduction, prisoner accountability, tool control, etc., can significantly improve staff and offender safety, as well as increase the public safety of surrounding communities.

Finally, if facility reviews reveal that one or more facilities have significant issues, the CDCR should consider the possibility that the issue may be systemic rather than local. In these cases, the CDCR should develop a comprehensive approach to addressing these issues. Other states with similar issues have used staff from other facilities to conduct unannounced lockdowns and searches of problematic facilities. Another best practices approach is to permanently or temporarily transfer and re-assign staff and offenders to different facilities. Both of these approaches have proven to be effective in turning around problematic facilities.

[Seal]

REFORMING CORRECTIONS

Report of the Corrections Independent Review Panel

Presented to

Governor Arnold Schwarzenegger

June 2004

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[1] A Reorganization Plan for Corrections

To a significant extent, the problems of California's Correctional system grow out of its structure. The Secretary of the Youth and Adult Correctional Agency, for example, has no control over line operations. Instead, the state's 32 prison wardens and eight juvenile institution superintendents each operate independently, with little consistency in procedures and minimal help from headquarters. Lines of responsibility are blurred by layers of bureaucracy between managers and functions. Accountability is conspicuously absent, as is transparency for the public into the system's inner workings. Clear, uniform policies governing the system's most vital functions—fiscal matters, personnel and training, internal affairs, information technology, and health care—are equally lacking. Boards, commissions, and other entities that have evolved over the decades perform duplicate and overlap-ping functions. And the system's organizational structure has not kept pace with the massive growth in inmate population or with the vast geographical spread of the institutions.

The sheer size and complexity of the correctional system, the critical nature of its mission, and the severity of the problems dictate the need for wholesale reform, and that reform should begin with the system's organizational structure. The Corrections Independent Review Panel therefore proposes that the state's correctional agencies be reorganized according to the plan described in this chapter. While the restructuring alone will not produce the necessary reforms, it will serve as the foundation for cleaning up the prison system, reining in costs, curbing misconduct, holding correctional administrators accountable for the system's performance, and making communities safer by doing more to ensure that inmates and youth wards leave custody better prepared to function in society.

Background

The state correctional system is presently comprised of the Youth and Adult Correctional Agency and its subordinate departments, boards, and commissions, which consist of the Department of Corrections, the California Youth Authority, the Board of Corrections, the Board of Prison Terms, the Youth Authority Board, the Narcotic Addict Evaluation Authority, the Prison Industry Authority, and the Commission on Correctional Peace Officer Standards and Training. The agency is organized as follows:

The Youth and Adult Correctional Agency. The Youth and Adult Correctional Agency was established in January 1980 with the enactment of California Government Code Sections 12850-12856. The agency is headed by the Secretary of the Youth and Adult Correctional Agency, who reports directly to the Governor and is responsible for general oversight of the agency's subordinate entities. The Secretary represents the Governor in overseeing correctional agencies and reports to the Governor on legislative, budgetary, and administrative matters affecting corrections, but has no direct operational responsibility for the subordinate departments, boards, and commissions. The Secretary is appointed by the Governor and is subject to Senate confirmation.

* * * *

[122] To address the length of time inmates spend in prison, the panel recommends eliminating the current time-credit system for non life-term offenses and adopting instead a "presumptive" sentencing structure that more effectively encourages inmates to achieve identified goals during incarceration. As an immediate measure to shorten prison terms, the panel recommends enhancing time credits inmates can earn in return for accomplishing specified goals. As a further means of reducing the prison population, the panel recommends identifying older inmates who could safely be released early, consistent with similar programs operating in several other states. To better prepare inmates for release, the panel recommends providing inmates with much greater access to in-prison education, vocational classes, life-skills training, re-entry services, and drug treatment. Those efforts should be guided by a research-based needs and risk assessment of each inmate upon entry into

prison and should include a programming plan designed specifically to address the inmate's identified needs.

To reduce the number of parolees who return to prison, the panel recommends changes that will enable parole agents to concentrate the most intensive supervision on parolees who represent the greatest risk to the community and improving services to help parolees reintegrate into society. The changes should include a risk-assessment of each parolee. The risk-assessment tool should be updated regularly to reflect any changes in the demographics of the parole population. Parolees identified through risk assessment as very low risk should be discharged from parole after three months. In addition, the panel recommends increasing the number of substance abuse treatment beds in the community and continuing implementation of the Department of Corrections "new parole model," which includes prerelease planning, electronic monitoring, and residential treatment as an alternative sanction for technical parole violations. The new Department of Correctional Services should also implement effective research and data-collection capabilities to precisely identify the most effective and efficient methods of supervising parolees.

In implementing these reforms, the first order of business should be determining the operable capacity of the state's prisons-the maximum capacity of the prisons to house inmates safely and securely while providing effective education, training, and treatment. The second order of business should be to determine the appropriate staffing needed to operate each prison and to provide inmates with needed programming. To improve strategic planning capabilities, the panel recommends that the new Department of Correctional Services contract with one of the state universities to undertake responsibility for inmate population projections.

Fiscal Impact

The department saves money with each inmate and parolee it safely removes from the prison and parole population. The present average cost of housing an inmate is $28,439 per year, and the average cost of supervising a parolee is $2,930 per year. Some of the recommendations presented here require an initial investment, but can be expected to save money in the future by improving the chances for inmates and parolees to succeed, thereby reducing the numbers who return to prison and shrinking the overall prison population. [123] Other recommendations may immediately reduce prison and parole populations and thereby produce savings upon implementation.

Laying the Groundwork for Reform

Every day, hundreds of thousands of inmates and parolees are housed, supervised, and moved around within the state prison and parole systems. Managing this population is complex and challenging. In today's environment, prison administrators must contend with severe overcrowding, the potential for violence, court mandates to provide constitutionally adequate conditions of confinement, budget cuts that have reduced staffing, and burgeoning inmate population levels, fueled in large part by former inmates cycling back into prison.

The key to reforming the system lies in reducing the numbers. That effort will require attention to sentencing practices, time-credit policies that allow inmates to reduce sentences, early-release for low-risk offenders, and a commitment to programs that help inmates and parolees reintegrate into society. For programming to succeed, in turn, the system must free up programming space and provide adequate staffing to provide program services and run the institutions. Strategic planning for that task will require accurate population projections, knowledge of the system's basic operable capacity, and a determination of necessary staffing levels.

Background

Operable prison capacity—the maximum capacity of the prisons to securely house in-mates and provide effective programming—differs from both design capacity and maximum "safe and reasonable" capacity. "Design capacity" is the term used for the past 50 years to designate the number of inmates a prison is designed to accommodate according to standards developed by the Commission on Accreditation and the American Correctional Association.[1] The number can be based on any combination of single-occupancy cells, double-occupancy cells, single- or double-bunked multiple occupancy rooms, or dormitories. The standards take into account the need for humane conditions, as well as the need to prevent violence and move inmates to and from programs, such as mental health care, education classes, and drug abuse treatment. In California, design capacity is based on one inmate per cell, single bunks in dormitories, and no beds in space not designed for housing. The design capacity of California's male prison system, including the capacity of the state's new prison at Delano, is 76,879 inmates. (*See* Table 1).[2]

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[1] California's actual prison capacity has never been limited to design capacity due to an ever-growing prison population. Actual prison population is represented here as a percentage of design capacity to provide a conceptual framework to convey the volume of prisoners that must be managed within the existing fixed environment.

[124] Maximum "safe and reasonable" capacity, in contrast to design capacity, refers to the maximum number of inmates who can safely and reasonably be housed in the prison system. That number takes into account the "safe and reasonable" capacity of individual housing units according to inmate custody levels, staffing levels, and the physical structure of the units. Level IV facilities, with a greater potential for violence, for instance, have a lower maximum safe and reasonable capacity than Level II and Level III facilities. The safe and reasonable capacity of each prison can be determined by totaling the safe and reasonable capacities of each housing unit in the prison, and the safe and reasonable capacity of the system can be estimated by combining the totals for each prison. The Department of Corrections has determined the maximum safe and reasonable capacity of the general population and reception center housing to be 190 percent of design capacity, while other housing can be filled only to between 100 and 160 percent of design capacity. Overall, the department has determined that the maximum safe

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[2] This report focuses primarily on the male prison population, which comprises 88 percent of the state's total prison population. According to the Department of Corrections "Monthly Report of Population as of April 30, 2004," compiled by the Offender information Services Branch, the institution population on that date totaled 161,394, with 141,763 male inmates and 9,638 female inmates in the state's prisons and 9,993 male and female inmates in other types of facilities, such as contracted jail beds, public and private community correctional facilities, and other placements.

and reasonable capacity of the state's male prisons is 137,764 inmates - 179 percent of design capacity.

Defining operable capacity. Operable capacity, which takes into account space needed for effective programming in addition to safety and security, is greater than design capacity, but far less than maximum safe and reasonable capacity. A group of experienced California prison wardens told the panel at a recent forum that the operable capacity of the state's prisons to support full inmate programming in a safe and secure environment is 111,309 inmates, or 145 percent of design capacity.

The state's prison system presently far exceeds operable capacity. California prisons are presently filled to the breaking point, with populations exceeding both design capacity and "safe and reasonable capacity," and far exceeding operable capacity. With 141,763 male inmates in a prison system designed to hold 76,879, as of April 30, 2004, the state's prisons were operating at more than 184 percent of design capacity. That number exceeds the prison system's safe and reasonable capacity by 4,000 inmates—and it exceeds operable capacity by 30,000 inmates.

Even those numbers understate some of the overcrowding. Accommodating the present inmate population has been accomplished by confining two inmates in cells designed for one, by double- and triple-bunking inmates in dormitories designed for single bunks, and by converting activity space into inmate housing areas. As Chapter 9 of this report notes, more than 9,500 male inmates are presently housed in activity space that was never designed for housing. Because Level IV inmates are generally more violent and cannot be crowded to the same degree as other inmate levels, Level IV celled housing units have now reached 152 percent of design capacity and may not realistically be filled beyond that point. As a result, greater numbers of inmates are forced into other housing, which has raised Level III housing to 201 percent of design capacity, and Level II housing to 220 percent. Consequently, the overall population of male prisons exceeds a safe maximum, and individual housing units in some prisons are so severely over-crowded as to be at a crisis stage. Reception centers, for example, which house all inmates entering prison, are housing a population of 20,000 male inmates in space designed for only 8,500—putting reception centers at 236 percent of design capacity.

* * * *

[130] mates to take the responsibility of completing the program plan and to officials who will have the responsibility of developing and administering it.

It is important to note that the recommendation for a presumptive sentencing model is to replace the current structure of determinate sentences only, as a means of including this sentencing method in a comprehensive correctional approach focusing on successful reentry. It does not include the current structure for life sentences or the "two-strike" and "three-strike" sentences, which are beyond the scope of this recommendation. In December 2003 there were about 90,500 inmates (58 percent) serving determinate sentences. The remaining 42 percent of the inmates were serving life sentences, two-strike, or three-strike sentences.[10] (Programs for these inmates should be developed as a secondary priority and are not considered in this report.)

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[10] California Department of Corrections, "Characteristics of the Inmate Population," Table 10, February 2004.

The Corrections Independent Review Panel expects that once fully implemented, a presumptive sentencing model would generate significant savings as inmates become better prepared for reintegration into society. The presumptive sentencing model would require further development by the new department, and the panel recommends that the new department charter a special commission to fully develop this important sentencing reform.

Goal-oriented sentence reduction credits could be increased quickly. Under the current sentence-reduction credit system, most of the department's inmates are limited to day-for-day credits, although some can earn more. (Fewer than 4,000 inmates housed in conservation camps earn two-for-one credits.) Inmates earn their day-for-day credits by participating in work, academic, or vocational activities; however, there is no requirement that the inmate fulfill any specific goals or even complete the training. The panel proposes that the department create a bonus sentence-reduction credit that would supplement existing credits and reward completion of education, vocational, or drug-treatment programs that are proven to reduce inmate recidivism.

This bonus sentence reduction credit would provide incentives for inmates' work activities by rewarding *completion* of academic, vocational, or drug-treatment goals. For example, an inmate could earn a 90-day sentence reduction for completing a literacy program or a college-level class, or a 180-day reduction for completing a drug-treatment course or a vocational certificate. Larger sentence reductions could be awarded to inmates who complete more rigorous programs, such as a two-year college degree. To implement this concept, the department would need to develop specific policies and procedures, and develop legislation to amend the California Penal Code to grant the authority for inmates to earn additional time credits.

Release of low-risk inmates to community supervision. Other states have successfully formed partnerships with law schools to identify and consider for release low-risk older [131] and geriatric inmates. The California Department of Corrections currently houses more than 3,700 inmates who are between 55 and 59 years of age, and nearly 3,100 aged 60 or older[11]. The Legislative Analyst's Office, in its fiscal year 2003-04 Budget Analysis, recommended that California consider early release of elderly inmates. In its analysis, the Legislative Analyst noted that California does not track the cost of incarcerating elderly inmates, but that several other states do and that these other states have estimated that elderly inmates cost two to three times the amount needed to house younger inmates. The Legislative Analyst further reported that New York, for example, estimated its annual cost of housing elderly inmates to be between $50,000 and $75,000 each. The National Center of Institutions and Alternatives estimated the annual cost of confining elderly inmates at $69,000 – nearly three times the national average of $22,000 to incarcerate other inmates.[12]

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[11] Department of Corrections, "Prison Census Data," December 31, 2003, Table 5.

[12] Legislative Analyst's Office, "Budget Analysis, Fiscal Year 2003-04," p. D-39

The Legislative Analyst's Office noted that housing nonviolent elderly inmates is not a good use of scarce resources when they represent a low risk to society.[13] While the majority of these offenders should remain in custody because of the serious, violent, or sexual nature of their crimes, a small percentage could be considered for early release. Statistics published by the U.S. Department of Justice indicate that recidivism drops significantly as inmates age—from over 50-percent nationally for inmates between ages 18 and 29 to about 2-percent for inmates aged 55 or older.[14]

In a December 2003 analysis for the Legislative Analyst, the Department of Corrections estimated that release of non-serious, non-violent inmates aged 55 or older would reduce the inmate population by 657 and result in savings of $10.5 million in fiscal year 2005-06, if these provisions become effective on January 1, 2005. In the first fiscal year, the institution population would be reduced by about 332 inmates, resulting in savings of $5 million. Full-year savings would occur in fiscal year 2006-2007, when institution population would be reduced by 657 inmates, resulting in savings of $11 million. The institution savings would be offset by the cost of supervising these offenders on parole. Also, these savings are based on the average cost of incarceration for all inmates.[15]

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[13] *Ibid* p. D-40

[14] U.S. Department of Justice, Bureau of Justice Statistics, "Trends in State Parole, 1990-2000."

[15] Is Department of Corrections, Legislative Estimates Unit, "Legislative Analyst Request 6," December 16, 2003.

In its calculations, the department assumed certain elderly inmates would be excluded from eligibility. Parole violators-returned to custody, inmates with life terms, second-striker inmates, sex registrants, and persons whose current or prior offenses are serious or violent (as defined in Penal Code, sections 1192.7(c), 1192.8, and 667.5(c)) were considered ineligible for early release.

Several states have released elderly inmates under a program created by George Washington University professor Jonathan Turley. Turley is the founder of the Project for Older Prisoners program, which uses a partnership between law schools and corrections depart-[132] ments to assess inmates for early release. To date, more than 200 inmates have been released under the program without a single act of recidivism.[16]

The Project for Older Prisoners program is likely to result in fewer early releases than the 657 figure estimated by the department because of its careful risk analysis and assessment of each inmate. This method is recommended, however, because of its conservative approach and excellent track record. Even if only one-quarter of the 657 inmates identified by the department met the more conservative criteria of the Project for Older Prisoners program, savings of $2.75 million could ultimately be realized.

Contracting with private companies for low-level inmates. The Department of Corrections currently contracts with several private corrections companies for about 2,500 beds for lower level inmates. In January 2004 the department discontinued contracts for about 1,000 beds. Privatized beds provide a high degree of flexibility because the department has no long term investment in the infrastructure or the staffing and can renew contracts on an as-needed basis.

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[16] George Turley, speaking at a sentencing seminar hosted by McGeorge Law School, April 16, 2004; Web-page viewed on March 25, 2004: www.gwu.edu/~ccommit/law.htm

Based on the projected Level I male institution population in 2009, the department will need more than 10,000 additional beds in order to house Level I inmates in a safe environment with programming opportunities.[17] Renewing contracts with the existing facilities and reentering into agreements with the previously closed facilities would help to provide the beds needed for this population, with no capital outlay costs to the state.

Recommendations

The Corrections Independent Review Panel recommends the following actions:

- Begin to create the environment in the prisons that is needed for inmate programs to be effective, which requires the following:
    - Implementation of a Violence Control Program;
    - Opening up program space by reducing prison population through lower returns to custody;
    - Adding staff necessary to implement, specific, effective inmate programs;
    - Exploring creative measures for the use of existing resources.

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[17] "Table 1: Analysis of Male Institution Bed Capacity, CIRP, June 2004

- Develop an interagency agreement with one of the state universities that is active both in corrections education and in research to undertake the responsibility for

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TABLE 1

Male Institution Bed Type (Includes Civil Addict Program)	Design Capacity (DC) updated on 6/2/04[1]	Actual Male Institution Population April 2004[2]	Actual Percentage of Design Capacity April 2004	CDC Defined Maximum % of DC	Male Institution Population Equivalent of CDC Maximum	Bed Changes Req'd to Reach CDC's Maximum Percentages	Warden's Proposed Operable Capacity (OC) as % of DC[3,4]	Male Institution Population Equivalent of Warden's Proposed OC	Projected Male Institution Population on 6/30/09[5]	Population Reductions Needed by 2009 to Meet Warden's OC[6]
CAMP BEDS	**3,588**	3,752	105%	100%	3,588	164	**100%**	3,588		
General Population										
Level I - MSFs	4,759									
Level I - old design	5,091									
LEVEL I TOTAL	**9,850**	15,751	160%	190%	18,715	-2,964	**150%**	14,775	29,054	-10,681
Level II - new design	6,406									
Level II - old design	9,622									
LEVEL II TOTAL	**16,028**	35,305	220%	190%	30,453	4,853	**150%**	24,042	31,334	7,292
Level III - standard	13,252						160%			
Level III - over/under	2,122						100%			
LEVEL III TOTAL	**15,374**	30,912	201%	190%	29,211	1,701	**152%**	23,325	36,215	-10,046
Level IV - 180 design	7,510						140%			
Level IV - 270 design	6,520						140%			
LEVEL IV TOTAL	**14,030**	21,293	152%	190%	26,657	5,364	**140%**	19,642	28,030	-3,591
Reception Center cells	5,646						150%			
Reception Center over/under	256						150%			
Reception Center dorms	2,608						190%			
RECEPTION CENTER TOTAL	**8,510**	20,055	236%	190%	16,169	3,886	**162%**	13,808	17,628	3,820
Administrative Segregation III	2,262						150%			
Administrative Segregation IV	1,152						120%			
AD SEG TOTAL	**3,414**	7,092	208%	150%	5,121	1,971	**140%**	4,779		
SUBSTANCE ABUSE TX	**1,056**	1,467	139%	140%	1,478	11	**140%**	1,478		
SECURITY HOUSING UNIT	**2,436**	2,780	114%	120%	2,923	143	**100%**	2,436	3,165	-729
CONDEMNED	**604**	604	100%	100%	604	0	**100%**	604		
YOUTHFUL OFFENDERS	**82**	82	100%	100%	82	0	**100%**	82		
EOP	**1,691**	2,397	142%	150%	2,537	140	**150%**	2,537		
PSU	**192**	248	129%	100%	192	56	**100%**	192		
PHU	**24**	24	100%	100%	24	0	**100%**	24	25	1
TOTAL SYSTEM	**76,879**	141,763	184.4%	179.2%	137,754	4,009	**144.8%**	111,309	147,481	36,172

Notes for Table 1

[1] "Design Capacity" (DC) is based on the following assumptions:

(1) one inmate per cell,
(2) single bunks in dormitories, and
(3) no inmates housed in spaces that were not designed for housing, such as dayrooms, hallways and gymnasiums.

The numbers used here provide a basis for expressing the actual capacity of the prisons as a percentage of design capacity.

Includes new beds at the Delano II facility.

[2] The population reflected here is the male felon and civil addict population housed in CDC institutions and camps. This population does not include (1) women, (2) inmates housed in various community correctional centers, (3) inmates housed in the Department of Mental Health state hospitals, and (4) inmates housed in county jail beds.

[3] "Maximum Operable Capacity" (MOC) is determined through an assessment of experienced Wardens and is expressed as the percentage of design capacity of the various housing units within the institutions wherein the prison can be operated both safely and can provide programming for every inmate, consistent with the inmate's ability. Programming means the provision of education, vocational education, drug and alcohol prevention and other programs especially for inmates serving a determinate sentence or PV-RTCs, which is consistent with a renewed emphasis on preparation for re-entry. For the purposes of the process of determining Operable Capacity, it is assumed that (1) all "bad beds" are closed, thus freeing up program space, and (2) staff with requisite experience are available to manage an effective program.

[4] Ad Seg and Level III maximum operable capacities are a weighted average based on the number of beds and the recommendations by bed type for the different designs.

[5] Based on Table 6 in the the Spring 2004 Population Projections, which has fewer breakdowns for inmate bed types. Campers, Administrative Segregation, Substance Abuse Treatment, Condemned, Youthful Offenders, EOP, and PSU inmates are included in the projections for Levels I through IV.

[6] Camp beds are included in Level I figures. Ad Seg beds are broken out between Level III and Level IV. Substance Abuse treatment beds are included in Level III. Condemned, Youthful Offenders, EOP and PSU beds are included in Level IV.

RESEARCH SERVING CALIFORNIA

CPCR REPORT

Understanding California Corrections

Joan Petersilia

A Policy Research Program Report

[Logo]

California Policy Research Center
University of California

* * * *

[64] When the sentencing system allows for some level of discretion related to release, the benefits of improved behavior are immediately apparent to inmates. In the absence of any hope to affect the amount of time they will serve, they are hardly going to line up to demonstrate that they can become model citizens. If the state's well-intentioned return to rehabilitation is to succeed, a careful reexamination of its approach to sentencing must be part of the overall picture. Inmates will choose rehabilitation only when it makes sense for them to do so.

Discretionary Parole Release

The shift away from indeterminate sentencing in 1976 spelled the end of discretionary parole *release*, but left in place post-prison parole *supervision* for all offenders, establishing an unusual hybrid system whose policy ramifications do not appear to have been fully clear to the individuals who created it. The historic record of the passage of the determinate sentencing law in the California Legislature reveals virtually no serious discussion of parole supervision at all, and interviews with those central to the law's passage indicate that the subject of parole supervision did not arise in the debate over sentencing. The assumption shared by all parties was that the previous post-prison parole system should and would simply remain intact. As an intellectual matter, the decision seemed to make sense. Over the long term, however, operation of the hybrid system has proven to be a significant contributor to California's unusually high recidivism rate.

The vast majority of state prisoners serve a period of parole upon release. Technically, a prisoner could avoid parole if the Board of Prison Terms exercised its power to waive parole, but a waiver of the entire parole period is extremely rare[168] In the overwhelmingly majority of cases, an inmate is simply released to parole supervision on the expiration of his or her prison term, with the parole term functioning not as a reward for good behavior (as it would in an indeterminate system) but as a period of extended surveillance and scrutiny during which the parolee may be recalled to jail on fairly minimal grounds.

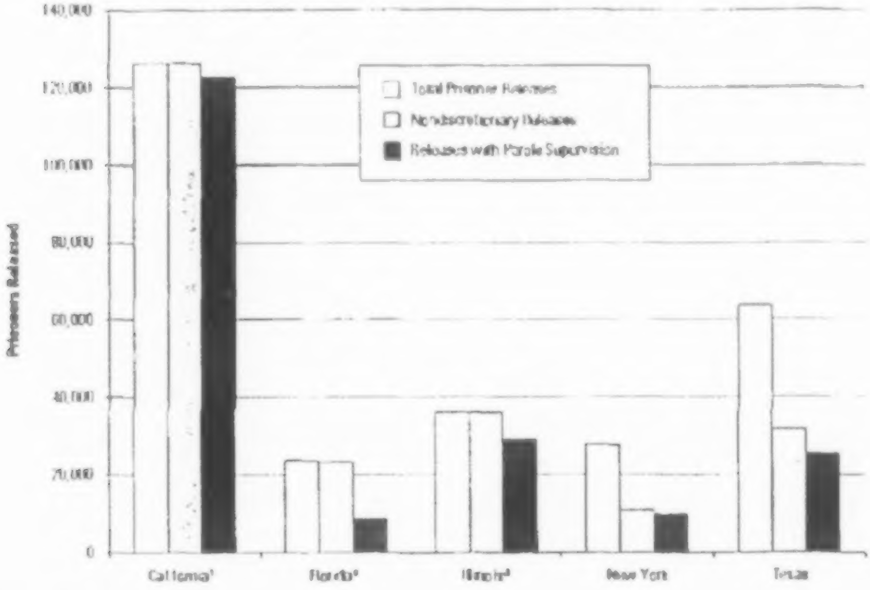
While on parole, a prisoner remains in the legal custody of the Department of Corrections and Rehabilitation. Thus, individuals who have been sentenced to prison are not free from restraints on their liberty until they have completed or are "discharged" from parole. During that period, a parolee is supervised by a parole agent, and must comply with parole conditions. If a parolee violates the conditions, the agent can refer the case to the Board of Prison Terms, which can revoke parole and order a return to custody to serve a parole revocation term. In addition, prisoners who are considered to be sexually violent predators or mentally disordered offenders may be subject to civil commitment proceedings and committed to a state hospital instead of being released from prison.

The length of a person's parole period is determined by statute. Most prisoners—those serving determinate terms for crime occurring on or after January 1, 1979—are subject to a three-year parole period, with a maximum parole period of four years.[169] However, the length of parole terms has been extended in recent years for certain offenders. Certain types of sex offenders, for example, are subject to a five-year parole term as a result of a 2000 amendment to the California Penal Code.

California's nearly universal application of parole supervision stands in sharp contrast to the approach used in most of the rest of the nation. Several other states supervise only certain high-risk prisoners after release. A few states, including Maine and Virginia, have abolished parole supervision altogether. Michigan supervises parolees for only two years, compared to California's three-, four-, or five-year supervision period. Other states, such as New York and Texas, release fewer inmates through a nondiscretionary process but apply parole supervision to

[65] FIGURE 32

Prisoners Released Without Parole Board Review and Parole Supervision, by State, 2004



Note:
1. Indicates determinate sentencing states.

Source: Data compiled from 2005 Directory, American Correctional Association, Lanham, Maryland.

all inmates who are released. Still others, such as Florida, release all inmates through a nondiscretionary process but apply parole supervision to fewer than half of those individuals. Only one other state in the nation—Illinois—follows the California hybrid, applying both a determinate sentencing system and universal parole supervision for nearly all released inmates. Figure 32 illustrates how unusual the hybrid approach is compared to the techniques applied in other states with large inmate populations.

Because California releases virtually all prisoners subject to the determinate sentencing law, with no opportunity to retain even the most likely reoffenders, and then places all of them on parole supervision, the state's parole officers end up supervising some individuals who pose a far more serious threat to society than the typical parolee in a state with discretionary release. In states that use discretionary release, these highly dangerous individuals aren't simply being put back on the street. In Texas, for example, only 63,790 inmates were released onto parole, with the state deciding to keep more risky individuals incarcerated. In California, on the other hand, parole officers often point out that their high revocation rates are caused by the behavior of parolees who were almost certain to reoffend and should not have been released from prison in the first place.

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REPORT ON SUICIDES COMPLETED IN THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION IN CALENDAR YEAR 2006

I. Introduction

This is the eighth annual report on completed suicides in the California Department of Corrections and Rehabilitation ("CDCR" or "Department"). It is submitted as part of the Special Master's continuing review of the Defendants' compliance with court-ordered remediation in *Coleman v. Schwarzenegger*. This report includes the demographic and mental health characteristics of those CDCR inmates who completed suicides during calendar year 2006, the timeframes for clinical and executive review and documentation of those suicides, plus individual case reviews by the Special Master's psychiatric expert ("this reviewer") of all 43 inmate deaths that, more likely than not, were the result of suicide.

As in past years, the *Coleman* Special Master's experts and monitors reviewed completed suicides during their regular site visits to CDCR institutions. They examined institutional records on completed suicides[1] and implementation of corrective action plans that were developed in response to past suicides. The Special Master's experts and staff further reviewed this information, which helped clarify the roles and responsibilities of the CDCR institutional and central office staff in the suicide review and prevention process.

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[1] Following the Special Master's distribution of this Report in draft form and accompanying case reviews of each completed suicide in 2006, defendants stated in their response that they had failed to provide any of the mental health records within

In addition, Plaintiffs notified the CDCR and the Special Master of their objections to the classification of some inmate deaths as non-suicides, the adequacy of the corrective action recommendations that emanated from the CDCR suicide review process, and facility responses concerning both clinical and custodial operations.

The demographic and mental health characteristics of the inmates who committed suicide are summarized in Tables 1 and 2, respectively. Appendix A summarizes the timeframes for clinical and executive review and documentation of completed suicides. Appendix B contains the case

* * * *

- [8] insufficient communication among clinical, medical, and custodial staffs
- failure to review documented histories in medical records, central files and/or referral forms

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the Unit Health Record for "Inmate T." Defendants then produced the missing records and asked this reviewer to conduct a second review of Inmate T's suicide, which has been done and is attached as part of Exhibit B. Defendants must ensure that no such lapses in their production of information occur again. Review of incomplete records can lead to erroneous conclusions and recommendations, and ultimately to allowing deficiencies in the defendants' suicide prevention efforts to remain undetected and uncorrected.

- lack of adequate and timely screenings and assessments of inmates on intake, placement in administrative segregation, transfers to other facilities, and referrals to clinicians for assessment of suicide potential in correctional treatment centers or other clinical settings

The finding that 72.1 percent of completed suicides in 2006 involved some measure of inadequate treatment or intervention and were, therefore, most probably foreseeable and/or preventable is consistent with findings of 74.4 percent in 2005, 76.9 percent in 2004, and 74.2 percent for 2003. These numbers are marked increases over the 45 percent rate of inadequate treatment that was found for suicides that occurred in 2002. In 2006, there continued to be inmates who were not considered for referral to higher levels of care, or were not placed on the mental health caseload, despite indications of their need for mental health interventions and/or psychotropic medications. There were also cases with documented concerns about the need for assessment of inmates who demonstrated significant mental illness, past suicidal behavior, or suicidal ideation or statements, and for their placement in higher levels of care.

The annual suicide rate per 100,000 inmates in CDCR since 1998 has been as follows:

1998 - 22 suicides in a population of approximately 158,159 Completed suicide rate of 13.9/100,000

1999 - 25 suicides in a population of approximately 160,970 Completed suicide rate of 15.5/100,000

2000 - 15 suicides in a population of approximately 160,855 Completed suicide rate of 9.3/100,000

2001 - 30 suicides in a population of approximately 155,365 Completed suicide rate of 19.3/100,000

2002 - 22 suicides in a population of approximately 158,099 Completed suicide rate of 13.9/100,000

2003 - 36 suicides in a population of approximately 155,722 Completed suicide rate of 23.1/100,000

2004 - 26 suicides in a population of approximately 163,346 Completed suicide rate of 15.9/100,000

2005 - Population of approximately 164,179. Completed suicide rate for 43 suicides of 26.2/100,000

[9] 2006 - Population of approximately 171,340 Competed suicide rate for 43 suicides of 25.1/100,000

III. Summary of Observations and Recommendations

From 1999 to 2006, the suicide rate for inmates in CDCR ranged from a low of 9.3 per 100,000 in 2000 to a high of 26.2 per 100,000 in 2005. Overall, for this eight-year period, the average annual suicide rate for suicides per 100,000 inmates was 18.5. For 2006, there was a slight drop in the suicide rate to 25.1 per 100,000, down from 26.2 per 100,000 in 2005.

As in past reports, a contrast appears between these rates and the national average for correctional institutions which was estimated at 14 to 17 per

100,000 during the period from 1998 through 2006, and most recently at 14 per 100,000. The difference between the national rates and CDCR rates has provided a standard by which the Department's record in dealing with suicides can be measured. It also provides a measure against which to determine the adequacy of the Department's suicide prevention efforts.

This report indicates that 72.1 percent of the suicides completed in 2006 involved some measure of inadequate assessment, treatment, or intervention, and were therefore most probably foreseeable and/or preventable, based on the definitions used in this review and the information that was or should have been available to clinical staff. This finding is consistent with similar findings in 2003, 2004, and 2005, as stated above. There continued to be significant substantive inconsistencies and inadequacies in the application of policies and procedures, as well as in staff performance with regard to suicide prevention and management.

As in past years, in 2006 there were improvements in the Department's policies and procedures. There were some advancements by CDCR toward improved suicide prevention policies and procedures during 2006. On October 2, 2006, CDCR submitted to the *Coleman* court its Plan to Address Suicide Trends in Administrative Segregation Units ("Plan"), and on December 1, 2006, it filed its amended Plan. This Plan was drawn in response to a court order entered on June 7, 2006, following a set of recommendations made by the *Coleman* Special Master to curb a disturbing rising trend of completed suicides in CDCR administrative segregation units. Although development and implementation of the Plan was still incomplete by the end of 2006, CDCR had begun taking positive steps toward it implementation. In October 2006, CDCR began requiring thirty-minute welfare checks of inmates during the initial three weeks of their stays in administrative segregation. It had also devised a plan to modify the large-mesh ventilation screens in 406 administrative segregation intake cells, with a schedule to modify 61 by April 2007, 85 by July 2007, and the remaining 255 by September 2007. In addition, CDCR submitted as part of its Plan a procedure and timetable for pre-placement screening of inmates endorsed for transfer to administrative segregation units, to be implemented by June 2007. CDCR also committed in its Plan to reviewing and proposing revised regulations in order to allow certain items of personal property for those inmates in administrative segregation for non-disciplinary reasons, and to providing those proposed revisions by December 29, 2006 to CDCR executive staff for their review.

* * * *

[1] REHABILITATION AND RECIDIVISM REDUCTION PRINCIPLES

In my opinion, the major barrier to the successful implementation of AB 900 is our long-term level of unacceptable overcrowding. One of our principle goals should be "100% employment in a work/training assignment for all available inmates."

- In order to attain 100% of the inmates available for assignment and to facilitate rehabilitation and recidivism reduction, the department's longterm goal must be to operate all of its prisons at design bed capacity.
- The department should establish an acceptable level of emergency overcrowding at:
    - 130% for celled institutions
    - 120% for dormitory institutions
- The above is based on the following:
    - Develop an assignment waiting list based on seniority.
    - "The number of inmates available for assignment will fluctuate based on the below-listed factors:
        - Mandatory inmate orientation – quarantine upon reception to the institution.
        - Administrative Segregation status
        - Medically unassigned
- The lower percent in a dormitory facility is based on the assumption that fewer inmates will require administrative segregation based

on discipline and/or special needs separation from the general population.

- The Federal Bureau of Prisons has a policy of an acceptable level of overcrowding of 130%.
- Based on the above principle/policy, we should establish as a point in our "infill bed" New Prison Policy Guidelines the following:
    - In order to achieve full employment/program in a wor/training assignment for all inmates in newly constructed "infill beds" and NOT jeopardize 100% employment for the existing inmate population at design bed capacity NO existing program and/or support space will be utilized to accommodate the additional infill population.
    - [2] Existing vacant program space was driven by continual unallocated budget cuts. Program staff is always the first to be cut. This is exacerbated by the level of overcrowding.
    - Unreasonable levels of long-term overcrowding has facilitated the following cause and effect:
        - Staff creates barriers between themselves and the inmates.
        - Principles of direct supervision disappear.
        - Loss of communication/knowledge regarding the inmate population.
        - Loss of control.

  - Drives up paper work; i.e., inmate disciplinaries and appeals which takes supervisors off the line to handle.
  - Higher levels of violence.
  - More frequent and longer lock-downs, etc.
  - Lack of health care space which has driven four major law suits *Plata*, *Coleman*, *Armstrong* and *Perez* and Federal receivership on Plata.

- In addition, the Receiver is building his team to reach out and provide the necessary Health Care space to fulfill his mission and will not be competing for space to build but will have first priority on any "dirt" available. This gets more complicated in that any infill beds we build inside the security area of an existing prison will require additional health care space. We can expect a negative response from the Receiver regarding this issue.
- You cannot have it both ways – we put the "R" back in CDC or we run a punitive overcrowded jail.

To me, these are a few basic threshold issues that need to be discussed.

5/31/07

AB 900 Strike Team ISSUE MEMO NO. 1
(Revision #) 3

SUBJECT: VALIDATION OF IN-FILL BED PLAN
Date: 8/13/07

Prepared by: Deborah Hysen,
Chair, Facilities Strike Team

Reviewed by: CDCR Executive Cabinet

ISSUE: VALIDATION OF INFILL BED PLAN

The CDCR In-Fill Bed Plan, drafted prior to AB 900, and for which AB 900 cost estimates were based, must be validated to ensure that the planning assumptions, including the selected sites and related feasibility assessments, building models, cost estimates and schedules appropriately meet the legislative intent of AB 900, the legal requirements imposed on CDCR in statute or through court order, and the expectations of the Administration in public safety and inmate rehabilitation.

PROBLEM AREAS OF IN-FILL BED PLAN:

1. Bed Types by Population/Level: There is no definitive forecast detail that illustrates the housing type that CDCR should be building to meet short, mid and long range bed needs of CDCR's inmate population at existing institutions. The original AB 900 in-fill bed solution assumes the Department's greatest need is to build "dorm" facilities for Level II offenders primarily despite the Infill Gap Chart identifying a significant gap of Level IV housing by 2012. Additionally, a number of unknown but critical factors that affect the population mix need to be considered and included before permanent construction can begin.

The Department should be building permanent solutions to meeting its population needs in the short, mid and long-range future and barring definitive determination of offender levels, it should provide the maximum flexibility to meeting the future inmate population and should have contingency planning in place that incorporates changes in populations based on unpredictable circumstances.

2. Housing/Program Space Allocations and Costs: The January 2007 In-fill Bed plan if implemented would not meet the AB 900 requirement which states "any new beds shall be supported by rehabilitative programming for inmates, including, but not limited to, education, vocational programs, substance abuse treatment programs, employment programs, and prerelease planning."

   [2] Additionally, if each housing unit is crowded to 200% of capacity, the efficacy of any program delivery method may be compromised. The costs authorized per AB 900 for housing and program space are based on project scope and cost estimates of the CDCR January 2007 In-fill Bed plan. A preliminary review of these costs indicates that they are insufficient to facilitate the rehabilitation envisioned per AB 900.

   The Department needs to build sufficient housing allocations and program space to deliver effective rehabilitation of inmates. If additional funding cannot be identified, strategies must be developed to maximize the funding available to the Department.

3. Construction Schedules: The In-fill Bed Plan provided unrealistic schedules for construction

based on a combination of accelerated construction methods for which it does not have authority to use (i.e. Design Build). Additionally, the schedules did not include a sufficient amount of time for the processes required in a state public works project such as finance and legislative approvals, public review periods, bidding and materials procurement, etc.. A preliminary review indicates that in order to develop accurate schedules for the proposed scope of work may add 6-15 additional months. With the current schedules, and the continued lack of special authority, the Department will not be able to provide permanent overcrowding relief for at least 2 years within its own facilities.

The creation of accurate schedules is critical to begin to prioritize and begin this work. Additionally, the current schedules must identify opportunities to compress forecasted timelines through the application of sound project management techniques, identification of "fast-track" methodologies and implementation on concurrent activities. CDCR management must seek remedy of several currently required state processes if it is to quickly mitigate its overcrowding through the construction of permanent facilities.

PROPOSED SOLUTIONS:

There are a number of things that must be changed within CDCR and with the full cooperation and collaboration of stakeholders engaged in these prison reform efforts in order to ensure the solutions brought about through construction address the basic mission of AB 900 - to ease the housing overcrowding condition confronting CDCR, as well as local jails, and its impact on providing adequate levels of inmate custody, health care and rehabilitation through a combination of new construction, increased programming, improved management function, and misc. departmental reform efforts. Some immediate changes have been identified to correct some of the deficiencies identified in the In-fill Bed Plan and are outlined in brief below. Additional modifications to the In-fill Bed Plan are being reviewed by the Strike Teams and various CDCR personnel and will be presented for further [3] consideration in a revised In-fill Bed Plan Addendum. These modifications should be complete by 8/31/07 and incorporated in the amended In-Fill Bed Plan.

The below recommendations represent the interim solution pending further resolution of the remaining beds to be constructed in the proposed In-fill Bed Plan Addendum. Further detail concerning these recommendations, and alternatives considered, is contained later in this memorandum.

Overall Recommendation and Goal Statement: Develop a revised In-fill Bed Plan that provides the right type of housing solution for the current and forecasted inmate population with the required amount of programming and support space within expedited timelines and with emphasis on cost efficiencies. This can be accomplished by implementing the following strategies to address the identified problem areas.

A. BED TYPES:

1. Build Fast-Track/High Impact Beds

a.) Erect Modular Level II housing dorms: Conduct cost/benefit analysis of permanent modular housing for Level II offenders within the secure perimeter of select facilities where existing infrastructure and contractor access facilitates expedient and cost-efficient construction. PIA does not currently offer modular housing alternatives, and prior studies have shown that upon final analysis, and in consideration of design criteria, financing limitations, site preparation and functionality, these units have not previously proven to be "cost effective". However, an updated analysis is warranted based on improvements in construction and delivery methods for this growing segment of the prison construction industry.

b.) Build "low-risk" Reentry dorms at select MSF sites: The In-fill Bed Plan should be amended to design and build some 100-bed dorm housing units at existing MSF sites to serve primarily Level II offenders classified as "low security risk" serving their last 6 months or less of incarceration. These sites will function as "mini-reentry" facilities. These dorms will be based on previously built prototypes and constructed at sites where CEQA (leverage reviews already in progress) and other site constraints provide the least impediment to their construction. With a negative declaration process, these beds can be delivered commencing in the Spring of 2009. These beds will have full and intensive programming aimed at a) modeling reentry programs on a small scale for full implementation on the larger community reentry facilities and b) providing successful reintegration opportunities for the initial prison population released either prior to the initial reentry facilities or those inmates returning to a county that has not planned a reentry facility. Sites selected will be within 100 miles of an urban population and inmates closest to that urban area will be housed in that facility.

[4] c). Develop Substance Abuse Level I dorm housing at select MSF sites: The In-fill Bed Plan should be amended to design and construct units of 100 beds each at select MSF sites to function solely as a self-contained Substance Abuse Treatment Facility for Level 1 offenders, including parole violators with identified substance abuse problems who would bypass general reception intake. This process would follow a similar timeline of Item 1b above, presuming a Negative Declaration process and use of prototype dorms previously installed by CDCR.

2. Build Mission Critical Beds

a.) Reception Beds: The CDCR needs to design and construct more reception beds to meet its intake needs. Existing institutions not designated as reception facilities are handling this load, though the designs are not conducive to these activities. By building additional reception facilities at existing institutions, existing prisons can return its currently designated reception centers back to their intended uses and gain greater operational capacity as a result.

The In-fill Bed Plan should be amended to construct up to 11 wing-nut celled housing units at North Kern State and Wasco State Prison for reception processing within the existing secure perimeter of those institutions. In addition, the Plan should be amended to design and build a 500-celled reception facility at the California Correctional Institution (CCI) - the intent being to refresh and harden the 500-bed "quick build" facility at CCI to a Level IV facility. All other institutions should be analyzed to assess the addition or relocation of reception center activities as part of the amendments to the Bed Plan.

b.) Substance Abuse Beds: The CDCR needs to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates within existing facilities. Since evidence-based research has indicated that these types of beds should be designed and located in an environment conducive to therapy and the creation of a self-contained "therapeutic community", it is imperative that these locations are identified and a plan to design and construct them, or otherwise designate them as "separate areas" within existing housing units, is included in the amended In-fill Bed Plan. There are currently no designated sites for these beds in existing institutions and no agreed-upon building prototypes for new construction of these beds.

c). Secure Housing Facilities: The In-fill Bed Plan proposed the addition of a number of secure housing facilities within the secure perimeter. These facilities should be built in the areas identified in the Infill Bed Plan provided that a site survey is conducted at each proposed site and the conclusions regarding placement and building adjacencies indicates that the housing units are appropriately located. (Note: The standard prototype for these facilities shall be reviewed and modifications considered during the design process to meet the rehabilitation goals of AB 900 and any previous court-ordered design changes).

[5] d). Health Care Facilities: The Federal Receiver in the Plata court case is in charge of administering health care, and the court-appointed representatives overseeing mental health and dental services, have vested interests and/or designated roles in the design, construction, and operation of health care facilities within CDCR's prison popula-

tion. The Infill Bed Plan must be amended through collaboration with and approval of these various authorities to site, design and construct facilities both inside and outside of the secure perimeter of the affected prisons. These additions must be incorporated early in the planning process to identify costs, design and construction activities (as applicable), and accurately reflect these locations because of construction, adjacency and operations issues.

3. Build Appropriate Security Level Beds

a). Increase celled housing proposed in In-fill Bed Plan: The In-fill Bed Plan illustrated a significant shortage of celled housing by 2012 for Level IV offenders. Inasmuch as it is unlikely the reentry facilities will provide a significant amount of Level IV housing, CDCR must build more cells to accommodate this population.

The In-fill Bed Plan should be amended to design and build a 500-bed semiautonomous unit at Kern Valley State Prison initially. This site will be constructed on "green fields" outside of the secure perimeter where contractor access is easily provided. This should serve as a model that can be deployed state-wide and can be modified as necessary to provide either celled or dormed housing, or a combination of the two within the same unit.

b) Forecast cell vs. housing needs: The Strike Teams, OFM, DAI, and other CDCR entities should analyze the remaining prisons and amend the In-fill Bed Plan to identify changes to the ratio of cell vs. dorm housing. The amended plans should optimize the ratio of beds by need and further the goals of rehabilitation and recidivism reduction.

B. HOUSING/PROGRAM SPACE ALLOCATIONS (AND RELATED COSTS)

1. Build Housing Space to Industry Standards

a). Establish new AB 900 Housing Goal of "Not to Exceed 145% Design Bed Capacity (DBC): The In-fill Bed Plan, combined with the plan for Reentry Facilities, should drastically reduce the inmate overcrowding occurring in CDCR in terms of overall population, but not in terms of individual housing allocations. The In-fill Bed Plan proposed to build new housing units at roughly 200% of design capacity, thereby crowding inmates in less space than is ideally designed and operated. This plan perpetuates a past practice of CDCR in contrast to industry [6] standards and in spite of the concerns of federal authorities on the conditions of overcrowding. The benefits of overcrowding to a % above DBC are the reduced requirements of square footage in some proportion to the number of beds. By amending the In-Fill Bed Plan assumptions to build beds at a "not to exceed" figure as proposed by the Independent Review Panel, it should be clear that this does not meet federal guidelines nor national standards but does begin to moderate and control the department's overcrowding practices. The AB 900 construction plans should revise the housing allocations to no greater than 145% average of DBC for inmate housing – if value analyses cannot reduce the overall costs of construction, and/or funding cannot be increased to meet this change, the total number of beds constructed pursuant to AB 900 should be reduced.

b) Establish Long Term Goal of "Not to Exceed 130% Design Bed Capacity (DBC): Upon completion of AB 900 construction, CDCR should ensure that as part of its Master Plan process that all new construction shall be based on planning assumptions that housing allocations shall not exceed 130% average of Design Bed Capacity. This limit is based on national standards for prisons. Further, consideration should be given to establishing planning capacity and oversight mechanisms to prevent the occurrence of exceeding this threshold.

2. Build program space relative to housing allocation/inmate population

a.) Reaffirm AB 900 goal of providing programming for all newly constructed beds: AB 900 provides for full programming for all new beds but AB 900 budget estimates covered only 50% of the beds. Given the extensive costs identified to correct this circumstance, it may not be feasible to build the requisite amount of permanent space. CDCR entities and Strike Team members should assess the ability of CDCR to now effectively deliver programming via double shifts to determine the programmatic viability of constructing less programming space maximizing the utilization of space to be constructed. The In-fill Bed Plan should be amended to reflect those changes if they are viable.

b.) Optimize existing program space to benefit remaining inmate population: The existing population has been deprived in many instances of full programming, partly as a result of CDCR's historical practice of building jobs and space for 100% of design bed capacity for the inmate population, which has then been overcrowded to a system average of 200% or more, and due to funding cuts, staff shortages and use of programming space to house inmates below 100% has resulted in further reduction of program capability below 100%. The Infill Bed Plan should identify opportunities within the existing funding constraints to renovate and reactivate dormant program areas for existing inmate populations.

[7] C. CONSTRUCTION SCHEDULES

The In-fill Bed Plan construction schedules are unrealistic, particularly in light of the lack of authority to accelerate construction based on proven industry-standard design and construction principles. The Infill Bed Plan must be amended to reflect accurate construction tasks, steps for review and approval, including the development of accompanying "master plan" documents required by AB 900 and incorporation of outside activities ongoing and related to institution operations, including installation of technology, recruiting efforts, medical facility construction and ongoing repair and improvements. A "master schedule" by site and in total is necessary to accurately predict, coordinate and report on these efforts.

APPROVAL TO PROCEED

The Facility Strike Team requests approval to proceed to continue its efforts with CDCR entities to finalize and amend the In-fill Bed Plan for presentation in full to CDCR, the Administration and other designated entities immediately after amendment on or about 8/31/07.

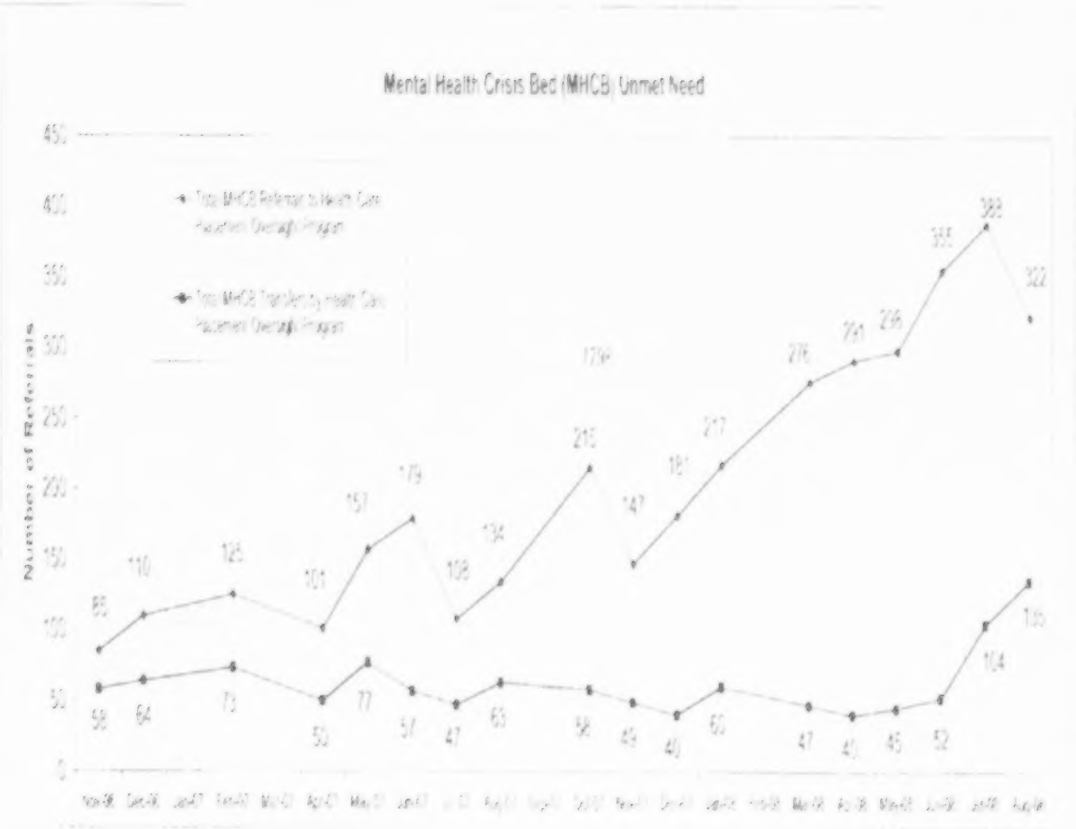
California [Logo]
Department of Corrections
and Rehabilitation

Prison Reform and Rehabilitation

* * *

> *"The Department of Corrections owns the responsibility to assist inmates who are willing to change their ways with basic tools, of education, life skills, drug treatment and mental health, so they can get better when they leave Corrections—not worse. But until I get overcrowding reduced—then I don't have the opportunity to provide the program that I believe is my charge."*
>
> *CDCR Secretary James Tilton*

* * *

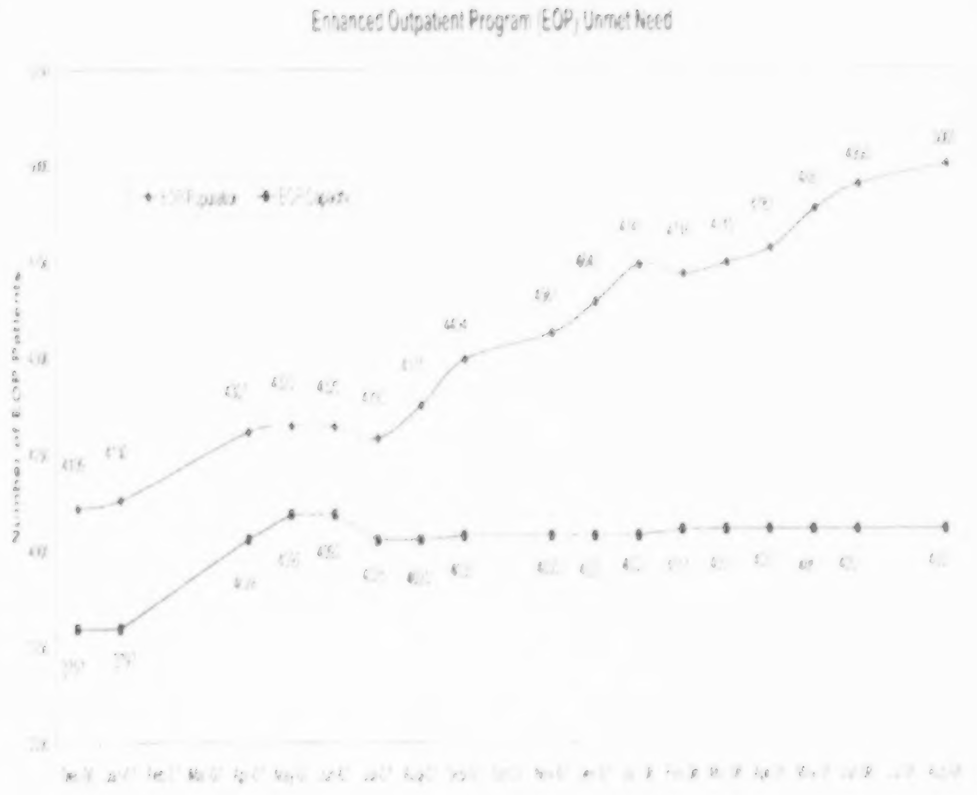


	Nov-06	Dec-06	Feb-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Oct-07	Nov-07	Dec-07	Jan-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08
Total MHCB Referrals to Health Care Placement Oversight Program	85	110	125	101	157	179	108	134	215	147	181	217	276	291	296	355	383	322
Total MHCB Transfers by Health Care Placement Oversight Program	58	64	73	50	77	57	47	63	58	49	40	60	47	40	45	52	104	135

Please note that missing monthly data reflect those months for which a report was not provided by CDCR.

Source: CDCR's Monthly Summary of Inter-Institutional Mental Health Crisis Bed Referrals and Transfers, Health Care Placement Oversight Program, Division of Correctional Health Care Services. Coleman Plaintiffs' Trial Exhibits 119-135; Joint Plaintiffs' Trial Exhibits 328-329

1799



EOP Capacity: [illegible] Enhanced Outpatient Program [illegible]

EOP Population: [illegible] Enhanced Outpatient Program [illegible] CDCR [illegible]

Please note that missing months [illegible] CDCR.

SOURCE: CDCR [illegible] Plaintiffs' Trial Exhibit [illegible] and Joint Plaintiffs' Trial Exhibit [illegible]

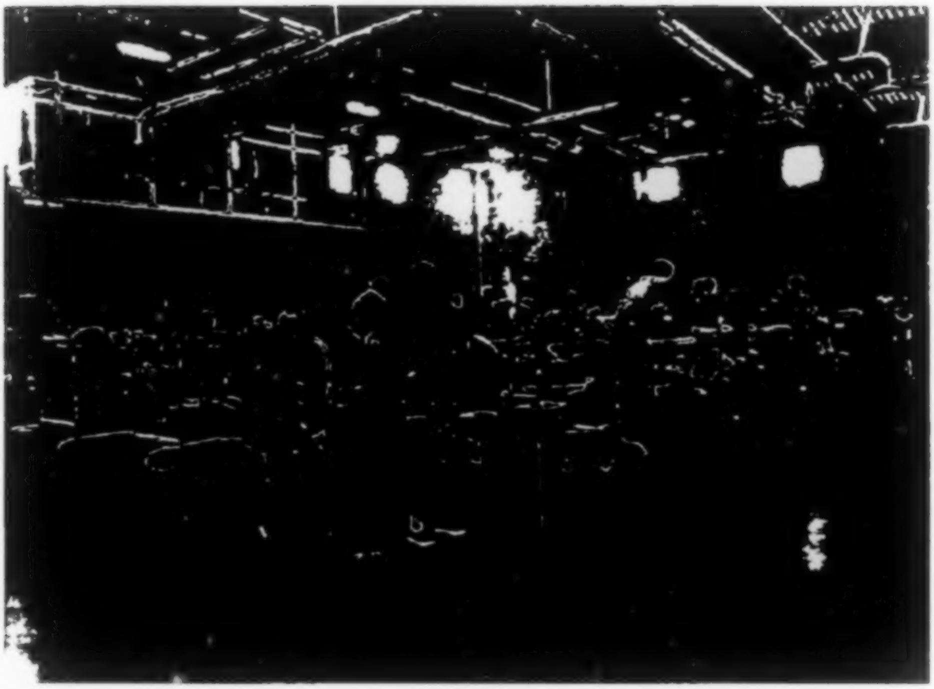
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
EOP CAPACITY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
EOP POPULATION	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

1800

SATF-11B

July 28, 2008

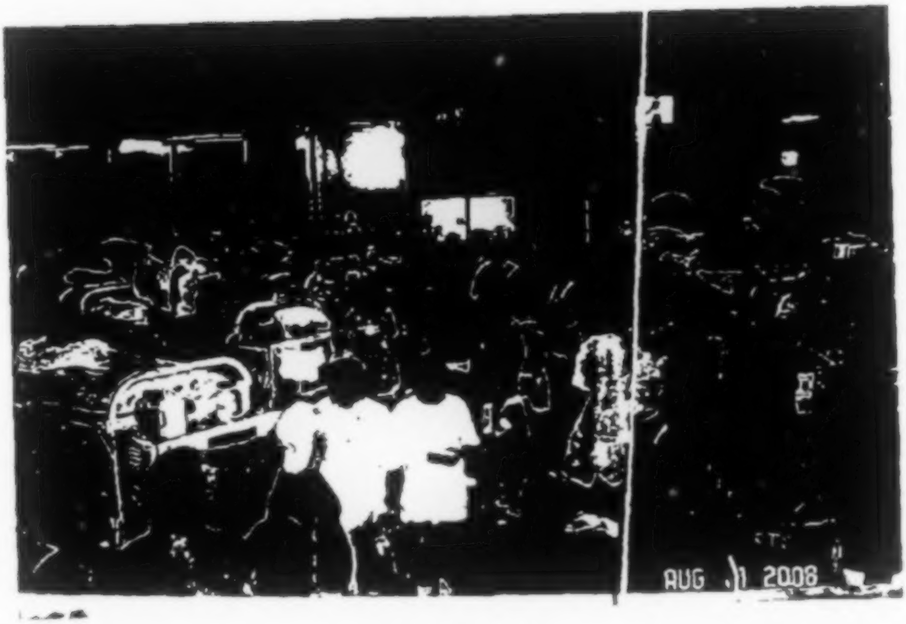
Facility A Yard Gym



CCI-8B

July 29, 2008

Reception Center, Yard 3 Gym Beds



MCSP-4B

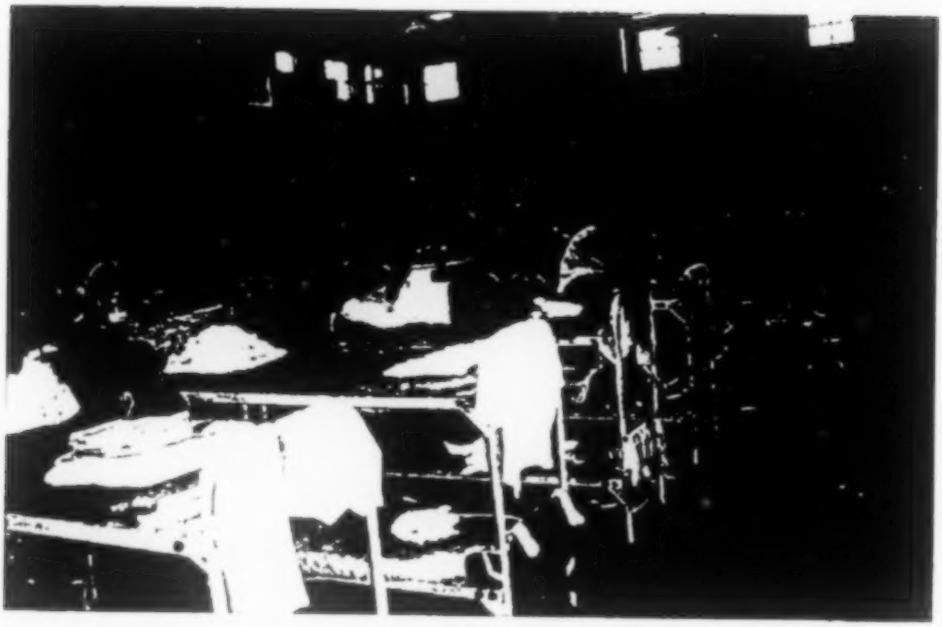
August 1, 2008

A-yard Gym Dorm

MCSP-14B

August 1, 2008

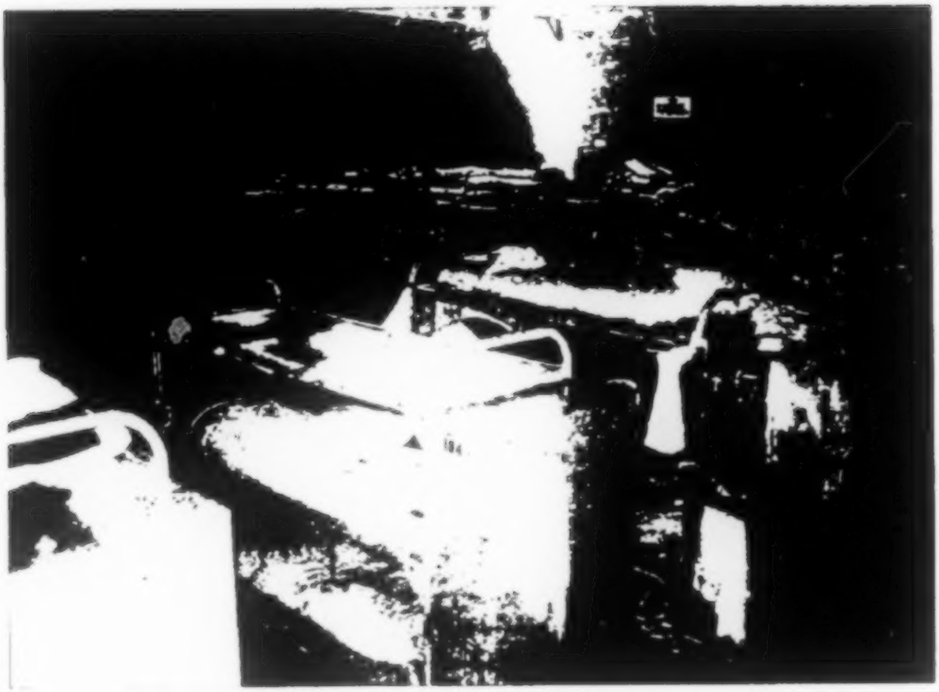
C-yard, Building 12 (ASU) picture of group cages



NKSP-13B

July 31, 2008

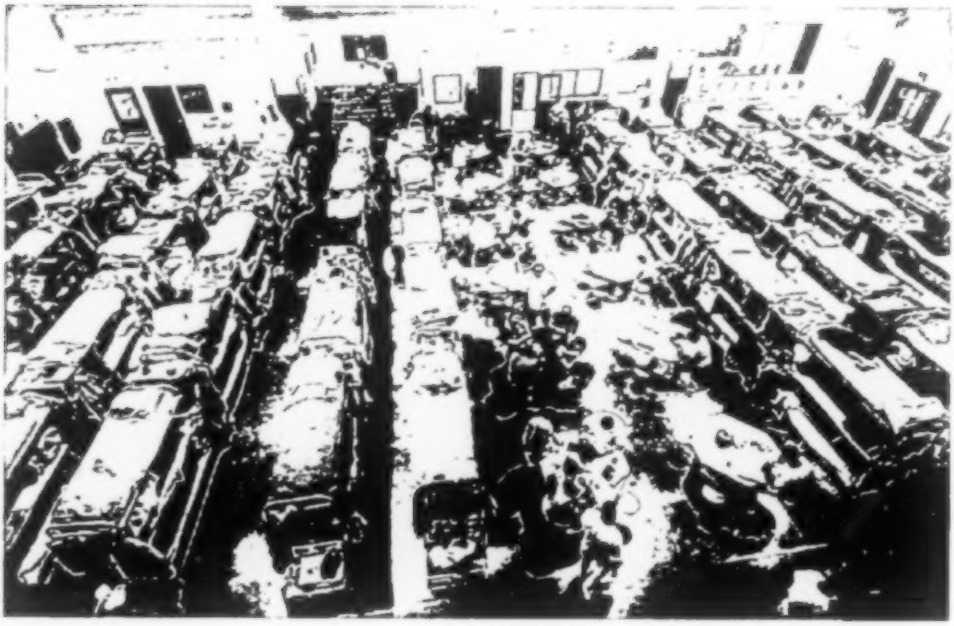
Facility A Gym

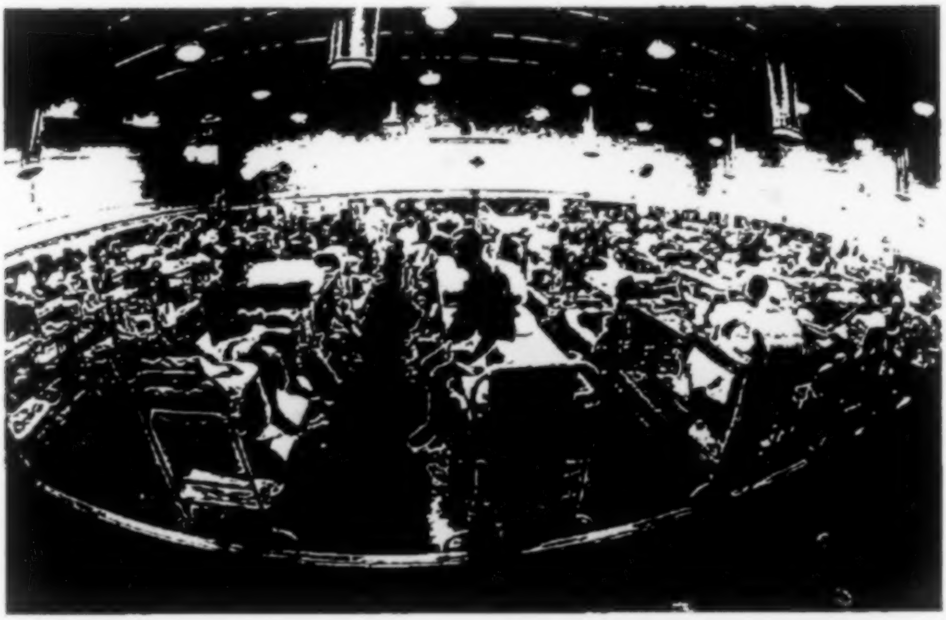


WSP-26

August 1, 2008

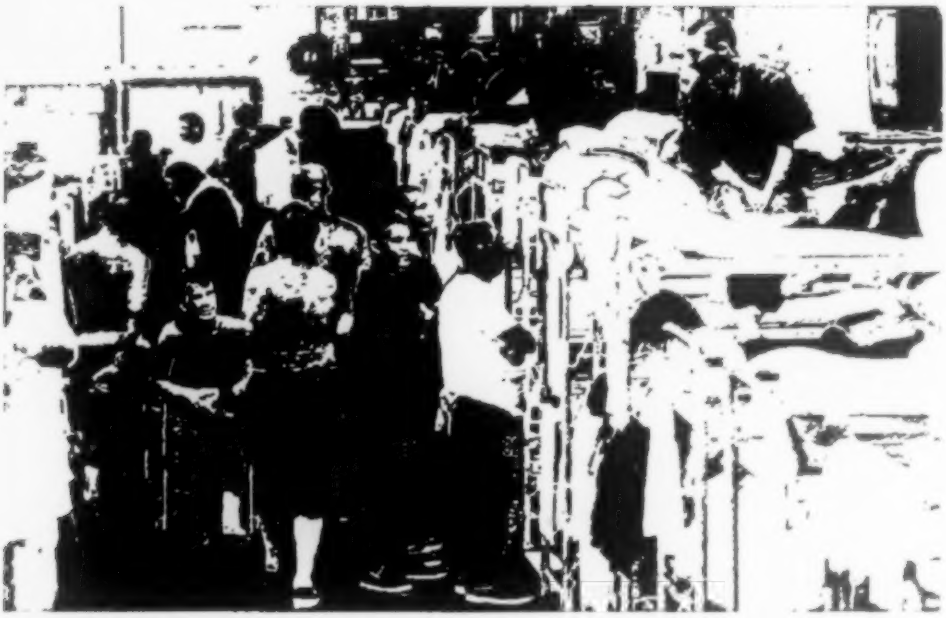
Facility A Gym





http://www.cdcr.ca.gov/News/images/overcrowding/CIM5.jpg

August 7, 2006

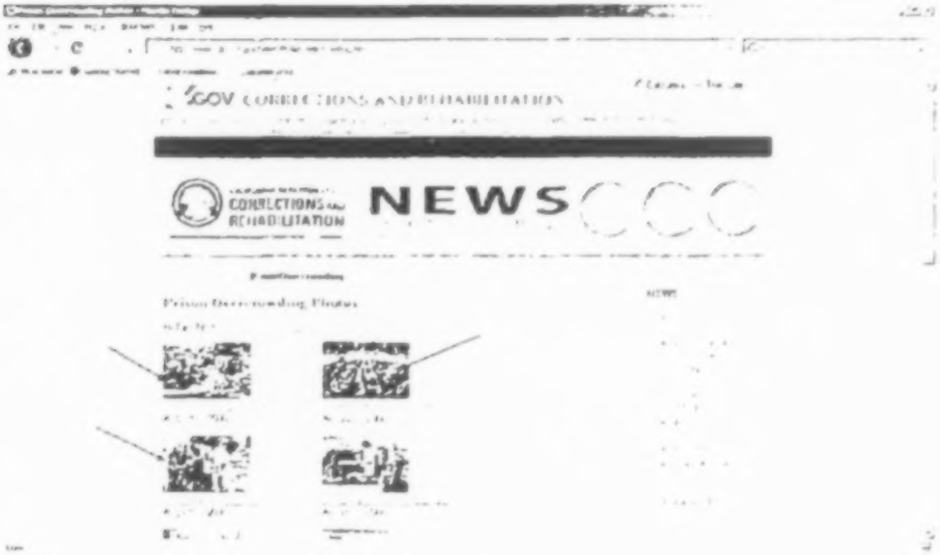


http://www.cdcr.ca.gov/News/images/overcrowding/CIM3_081006v3.jpg

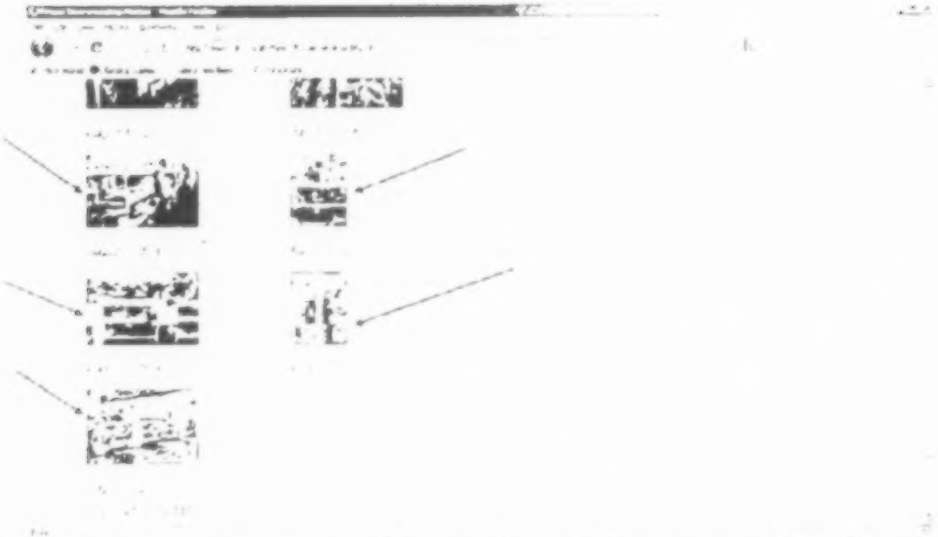
August 7, 2006

http://www.cdcr.ca.gov/News/images/overcrowding/CIM1_081006v1.jpg

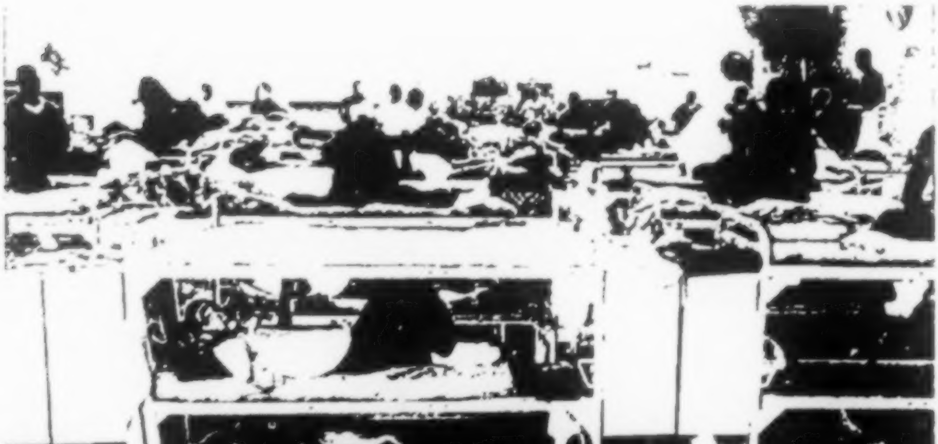
August 7, 2006


CA.GOV CORRECTIONS AND REHABILITATION
CORRECTIONS AND REHABILITATION
NEWS
Prison Overcrowding Photos
NEWS

http://www.cdcr.ca.gov/News/PrisonOvercrowding.html



http://www.cdcr.ca.gov/News/PrisonOvercrowding.html

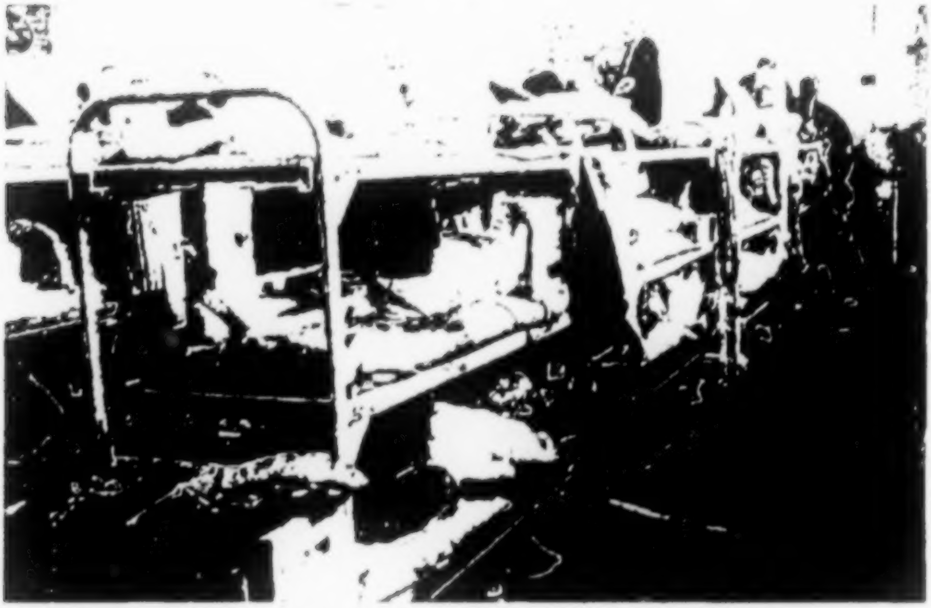


http://www.cdcr.ca.gov/News/images/overcrowding/CSP-Los-Angeles.jpg

August 8, 2006

http://www.cdcr.ca.gov/News/images/overcrowding/CSP-Los-Angeles1.jpg

August 8, 2006



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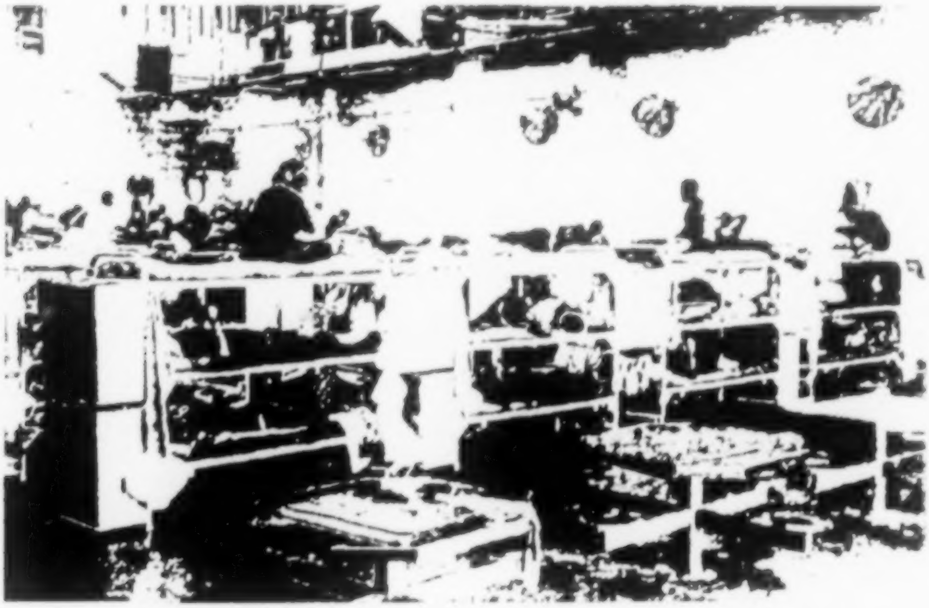
August 8, 2006



http://www.cdcr.ca.gov/News/images/overcrowding/csp-Los-Angeles4.jpg

August 8, 2006

http://www.cdcr.ca.gov/News/images/overcrowding/CSP
Los Angeles6.jpg

August 8, 2006

Plaintiffs' Exhibit 384

Transcript of Video

1:59 – 2:14

Governor Schwarzenegger: "I don't blame the courts for stepping in to try to solve the health care crisis that we have, the overcrowding crisis that we have, because the fact of the matter is for decades the State of California hasn't really taken that seriously, and hasn't really done something about it."

[000215] State of California

Department of Corrections and Rehabilitation

Memorandum

Date: August 20, 2007

To: James Walker, Warden (A)
Jasdeep Bal, M.D., Chief Medical Officer
Michael Jaffe, M.D., Chief of Mental Health
California State Prison – Sacramento

Subject EXECUTIVE SUMMARY OF SUICIDE REPORT

A clinical review of this case found the following

Name: CDC Number: Age: 31

Date of Death: May 28, 2007

Time of Discovery: 1644 Hours

Institution: California State Prison - Sacramento

Location of Death: B1-219, Mental Health Outpatient Housing Unit

Mental Health Level of Care: Correctional Clinical Case Management System

Manner of Death: Hanging

Summary:

On Monday, May 28, 2007 (Memorial Day holiday), at about 1644 hours, two officers in the Mental Health Outpatient Housing Unit approached cell 131-219, -Solely occupied by inmate [Redacted] a 31-year-old Caucasian (Italian-American) inmate who was on Suicide Precaution (q 15 minute checks) at the time.

When they approached the cell, the two officers saw that Inmate [Redacted] had a noose around his neck that appeared to be fashioned from strips torn from his suicide safety blanket, with the other end tied to the air vent. One officer immediately. activated his personal alarm while the other called for the cut-down kit. A third officer retrieved the kit from the control booth officer and responded to the cell, At perhaps 1648 hours (time difficult to read on fax), the officers called for the door to be opened, and entered the cell. An officer supported the inmate while cutting the noose and two officers lowered him to the floor. The program sergeant had arrived, and Checked for a pulse while an officer checked for breathing. When no pulse or respiration were detected, the officer immediately started chest compressions while a responding licensed psychiatric technician supplied breaths using a micro shield clear mouth barrier.

At approximately 1650 hours, the inmate was placed onto a Stokes litter and rolling gurney, and transported to the B Facility Clinic arriving at 1652 hours, with cardiopulmonary resuscitation continuing throughout the transfer. At the clinic the officer retrieved the automatic emergency defibrillator, applied the pads, and turned it on. Per the voice instructions of the device, officers [000216] continued cardiopulmonary resuscitation. Efforts to revive the inmate continued under the guidance of the rover registered nurse, the A-Facility registered nurse, the &-Facility licensed vocational nurse, a licensed psychiatric technician, and several officers. At 1653 hours the crash cart was opened, and an intravenous line started. At 1655 hours the medical officer of the day was called, who ordered an ambulance be called.

Epinephrine and atropine were administered several times. At approximately 1715 hours, the City of Folsom Fire Department paramedics arrived, and assessed the situation. After assessing the inmate and attempting life support, the paramedics ordered life support terminated at 1725 hours.

There was no suicide note.

Investigative Services processed the damaged suicide blanket and strips into evidence. This reviewer examined the blanket. It appeared that the strips had been cut from blanket with a very sharp object, such as a razor. Due to construction of this blanket, it could not possibly have been torn in such a straight line through all the quilted stitching. A long strip approximately six inches wide had been cut straight along two sides of the blanket, joined at the corner by the heavy banded seam. The shorter end was roughly cut through cross-wise; this was where the officers had cut to release the inmate from the vent attachment. Photos showed how this thick strip had been rather remarkably threaded through the small ventilation grid, and tied to itself. No blade was found in the cell following the suicide; and the inmate had been strip-searched when first placed into the cell.

Inmate [Redacted] apparently grew .up in an intact family in Long Beach, California. He reported a history of mental illness and heavy substance abuse including methamptamines. He reportedly history graduated from high school, but had virtually not work history, and evidently received disability for his mental disorder. His adult criminal history from 1995 - 2005 included arrests/convictions for carrying a concealed weapon on his person, reckless driving, making a false report of an emergency, theft, threatening crime with intent to terrorize, possession of marijuana, and arson. The controlling offense was arson of an inhabited structure. He set fire to a house with people inside, because he was angry at the owner. He was sentenced to eight years prison including an enhancement for another arson offense for which he had been serving probation. This was his first prison term.

The Probation Officer's Report noted that the inmate carried a diagnosis of Bipolar disorder and had taken medications for five years. He had perhaps a half-dozen psychiatric hospitalizations in the community, and a history of self-injurious behaviors and suicide attempts including jumping off a freeway bridge. His attorney asked the court to recommend Atascadero State Hospital, and the court agreed that he needed placement at a mental health facility. At the time of his sentencing, Inmate [Redacted] was in the jail psychiatric ward on suicide watch.

He was received at the North Kern State Prison Reception Center on May 19, 2006. Upon entering prison the inmate indicated he was currently taking medications and was immediately referred to mental health. His medications were continued just as they had been ordered in jail. Depakote ER 1000 mg pm, and Seroquel 400 mg pm. He had a Mental Health Screening on [000217] May 23, 2006, and a Mental Health Evaluation on June 7, 2006, placing him at the Correctional Clinical Case Management System level of care.

In prison Inmate [Redacted] was not a management problem. He had a minimal disciplinary history, and attended an education program. He did have a period where he had some conflicts with other inmates due to the fact that he had been mistakenly identified as Hispanic and custody had housed him with Hispanics. This was later corrected.

One month after entering prison, Inmate [Redacted] had the first of many emergency psychiatric evaluations and the first of about six mental health crisis bed status placements while he was at North Kern State Prison reception center. On each of these admissions he was described as extremely maniac and psychotic with grave disability, including symptoms of confusion, disorganization, lability, flight of ideas, pressured speech paranoia, irrational behavior, restlessness, confabulation, and suicidal ideation. However he quickly responded to medication, usually adjusted dosages of Depakote and Seroquel, and the controlled setting. He did not seem to recall his psychotic or manic episodes very well after he had been stabilized, as he would typically deny that he had ever been suicidal or had experienced the other symptoms that brought him to the crisis beds.

After one of his discharges at the end of August 2006, he was recommended for Enhanced Outpatient Program. A clinician followed him as "EOP" for a few weeks. However, this designation somehow got lost as subsequent chronos and documents continued to list him as Correctional Clinical Case Management System. He was seen for a final level of care assessment just before he transferred in January 2067, and at that time he had actually been stable for about six to eight weeks, so was continued as Clinical Case Management System level of care and transferred to Folsom State Prison on January 23, 2007. At that time his medications were Depakote, Seroquel, and Risperdal.

On February 28, 2007, Inmate [Redacted] saw the psychiatrist and expressed a desire to stop his Depakote, saying he had been skipping it and felt better without it, so it was discontinued. His Seroquel was also tapered off in 100 mg increments over 4 weeks (last dose 50 mg) until discontinued, and at the same time he was started on Geodon and titrated up in 20 mg increments over 3 weeks to 60 mg. He then saw the same psychiatrist again for follow-up on March 29, 2007, and complained of anxiety and shaking. He mentioned a family history of cancer. Geodon 40 mg am was added, continuing 60 mg pm. Risperdal was continued at 2 mg HS.

On April 12, 2007, Inmate [Redacted] saw his case manager, and complained that he was depressed and the medications did not seem to be helping. From that point forward, the inmate had numerous clinical contacts, sometimes several in one week. At his next contact, April 19, 2007, he started talking about the fear that he might have cancer or AIDS, and requested a medical follow-up.

The Medication Administration Record for April 2007 appeared to indicate that the inmate was not showing up for medication more often than not. Medication compliance had not seemed to be [000218] an issue before that time. He was again seen by a psychiatrist on April 23, 2007, and counseled about adherence to treatment. He was noted to be ambivalent about psychotropics, but willing to try just one medication. The Geodon was stopped, risperidone continued, and Benadryl added.

On April 29, 2007, the inmate told his case manager that he felt like he was dying of a disease, and was extremely anxious, hyper-vigilant, with excessive motor movements. He was immediately referred for a blood test that was performed "on the spot" to help reduce his anxiety about his medical condition. The case manager saw him again on May 3, 2007, and shared the results of his blood test, which were negative. Clinician noted that the inmate was somewhat unbelieving of the results at first, but seemed somewhat relieved. Some anxiety was still noted but talk therapy was encouraged.

He saw the psychiatrist again on May 8, 2007, who noted that he appeared depressed and anxious with some paranoia, and planned a trial of antidepressant as no manic symptoms were noted. Corresponding medication orders were for risperidone I mg am and 2 mg HS, Benadryl 25 mg am and 75 mg pm; and mirtazapine (Remeron) 15 mg HS.

On the morning of May 21, 2007, Inmate [Redacted] presented to mental health as a "walk-in" and saw another psychologist (not his regular case manager). He presented with "nervousness and physical shaking, and complained of "side effects". from his medications. He was referred for another medication review. He was noted to deny suicidal ideation at that time.

On the morning of Thursday, May 24, 2007, the inmate, again self-referred to mental health and was seen by the senior psychologists. He told her he had been feeling suicidal for one week, and could no longer keep from hurting himself. He said that he wanted to throw himself off the tier to kill himself. He described anxiety racing thoughts; and effects of drug 'addiction. He stated he had stopped taking Depakote, and that his current medications were not working. He wanted to get back on Depakote. He was noted to be depressed, malodorous, and coherent, with psychomotor agitation. A Suicide Risk Assessment was completed, noting High Risk.

Inmate [Redacted] was referred for crisis bed placement and transferred to the Mental Health Outpatient Housing Unit at the California State Prison, Sacramento. There he was admitted at 1015 hours and placed on suicide precaution ordered as Q 30 minute check, with a diagnosis of Amphetamine Dependence and rule/out Bipolar Disorder not otherwise specified. The only medication ordered was Remeron (mirtazapine) 30 mg Q HS. The Suicide Observation Record indicated that the checks were only done on an hourly basis, starting at 1445 hours when the inmate was actually placed in a Menial Health Outpatient Housing Unit cell.

The next day, May 25, 2007, Inmate [Redacted] told the psychologist that he was "ok" but did not want to come out of his cell to talk. He appeared to be depressed and while not suicidal at the moment, stated the ideation "comes and goes." The interdisciplinary Treatment Team meeting was held, indicating that the inmate did attend, and recommended admission to the Correctional Treatment Center Mental Health Crisis Beds. The Suicide Observation Record of May 25, 2007, [000219] had "Suicide Precautions Q 1 HR" pre-printed at the top; and "Q 15 min" written in as the ordered observation time, but the checks were only performed once an hour.

Over the next several days the inmate was seen cell side each day as he reportedly refused to leave his cell. He denied suicidality and appeared stable. On May 28, 2007, He was described as alert, cooperative, stable, absent of suicidal ideation for several days, and appeared ready to return to regular housing. The inmate was quoted as saying "I'm OK and ready to go back." The note was timed at 1146 hours. Suicide precautions at Q hourly checks were continued pending his return to custody, planned for the next day. He was found hanging that afternoon during hourly checks.

This inmate had a severe mental illness and rather poor insight. It appears that he responded well to mood-stabilizing and antipsychotic medication, and his frequent decompensations while at North Kern State Prison suggest the possibility that he was less than fully compliant with his medication, which would be consistent with poor insight. His lack of understanding of the nature of his Bipolar illness also led him to request medication changes that in hindsight may not have been wise, particularly the discontinuation of his mood stabilizer at the end of February 2007. When he saw the psychiatrist a month later, he was experiencing anxiety and shaking. Thereafter, he necessitated frequent clinical contacts, and continued to decompensate, experiencing strong anxiety and restlessness along with depression and paranoia. He developed the possibly delusional idea that he had a life-threatening Medical problem. He also talked about his past drug abuse. It seems that he was seeking an explanation for his severe internal discomfort, which was in fact most likely due to his mental disorder and decompensation as the medications wore off. At the last, he realized that he needed to be back on his Depakote, and requested this from the clinicians at Folsom State Prison.

He was appropriately referred to a crisis bed setting. He was prescribed an antidepressant, not a Mood stabilizer as he had requested. The standard of care was not adequate, as he was only given hourly checks and orders for more frequent checks were apparently disregarded. State policy requires checks at least every 15 minutes at staggered intervals. Had such frequent checks been done, the likelihood that he could have successfully completed an act of suicide would have been substantially decreased.

Recommendations:

Two issues noted without recommendations are whether the inmate should have been in the Enhanced Outpatient Program, and how he obtained a cutting instrument while in a Mental Health Outpatient Housing Unit.

The inmate was evidently referred for Enhanced Outpatient Program while at North Kern State Prison, but then this designation somehow disappeared and he remained in Correctional Clinical Case Management System when not on crisis bed status. It was not clear from the documentation that any formal decision was made about his designation at the time. His frequent moves in and out of crisis bed status likely contributed to any mix-up. However, just before his transfer, his [000220] level of care designation was reviewed and he was considered appropriate for Correctional Clinical Case Management System. Therefore, there is no recommendation.

At Folsom State Prison, the inmate programmed without incident for several months, until he stopped taking his mood stabilizer and started requiring frequent staff contact in mid-April 2007. Had the inmate lived, he should probably have been considered for referral to Enhanced Outpatient Program, however, given that he functioned well on medication, it is understandable that the staff were making an effort to re-adjust and stabilize him on his medication before making such referral. Therefore, there is no recommendation.

Documentation indicates that the inmate was stripped searched before being placed into his cell. According to custody, razor blades are easy to hide and extremely difficult to find. Another inmate could have fished a blade to him. After he used it, he likely flushed it. The other inmates were interviewed at the time by investigative services staff, and denied knowledge of precipitants or signs that the inmate was planning to kill himself. (Due to the high turnover of this unit, these inmates were not available when the reviewer visited the institution.) It is not clear what else could have been done to prevent the inmate from obtaining a blade, and of course it is not known for certain that he even had a blade. Therefore, there is no recommendation.

Identified Problem	Quality Improvement Plan	Required Supporting Documents
1. The standard for Suicide Precaution at California State Prison -- Sacramento was Q 1hr checks. Policy requires Q 15 min checks. More frequent checks would have made it	California State Prison - Sacramento to ensure that local procedure complies with the policy of staggered Q 15 minute random checks (i.e. not less than five checks per hour at intervals not greater than 15	Copies of new procedures and forms. Documentation of training given to nursing staff regarding Q15 minute staggered checks as the standard for Suicide Prevention

more difficult for the inmate to have opportunity to create a noose.	minutes) and that any forms such as pre-printed orders and nursing check sheets accurately reflect the standard of Q15 minute checks	
2. At North Kern State Prison, the inmate was in crisis beds or on crisis bed status multiple times, but was never considered for referral to Department of Mental Health as per policy	North Kern State Prison to submit copies of crisis bed placement los and Department of Mental Health referral logs, and audit admissions and discharges based on log for past 6 months for compliance with policy.	Copies of logs for the past three months, and summary of audit results.

According to the Suicide Prevention and Response chapter of the September 2006 Mental Health Program Guide the, Quality Improvement Plan shall be implemented within 60 days of the date of [000221] this memorandum. The institution is responsible for all recommendations unless otherwise indicated. *A final report of the completed Quality* Improvement Plan and supporting documentation are to be submitted to Helen Steenman, Ph.D., Senior

Psychologist Specialist, Mental Health Programs, Division of Correctional Health Care Services (DCHCS), within 30 days of implementation (i.e., 90 days after the date of this memorandum). The Warden and Health Care Manager must sign off on the final report.

If you have any questions, please contact Dr. Steenman, at (916) 327-0948. Her fax number is (916) 322-2838.

/s/ DOUG McKEEVER
DOUG McKEEVER
Director
Mental Health
Division of Correctional Health Care Services

/s/ [Illegible]
LEA ANN CHRONES
Director (A)
Division of Adult I

cc: George Giurbino, Associate Director, Division of Adult Institutions
Denny Sallade, Regional Administrator -North, DCHCS
Stephen Clavere, Ph.D., Chief Psychologist, Northern Region, DCHCS
Kathleen Allen, NurseConsultant, DCHCS
J. Michael Keating, *Coleman* Special Master
Matthew Lopes, *Coleman* Deputy Master
Michael Bien, Rosen, Bien & Galvan, LLP
Donald Specter, Prison Law Office
Raymond Patterson, M.D., *Coleman* Expert
Lisa Tillman, Deputy Attorney General, Department of Justice

Michael Stone, Staff Counsel, Office of Legal Affairs

Catherine Bernstein, Assistant Chief Counsel, Office of Legal Affairs

Karen Kelly, Ph.D., Chief Psychologist, California State Prison – Sacramento

Greg Hirokawa, Ph.D., Chief of Mental Health, North Kern State Prison

Cynthia Radaysky, Deputy Director, Long Term Care Services, Department of Mental Health

* * * *

[000228] 62 were offered as the diagnoses, the Axis II deferred. The problem identified for focus of treatment was mood swings. Current medications were noted to be Risperdal, Seroquel, and Depakote. A routine Suicide Risk Assessment Checklist did not note his many past suicidal behaviors at north Kern State Prison, and indicated No Apparent Significant Risk. On February 6, 2007, he was diagnosed with Bipolar Disorder, Methamphetamine Dependence, and a Global Assessment of Function score of 62 per MH-2 Mental Health Treatment Plan and chrono of care.

Inmate [Redacted] saw the psychiatrist on February 28, 2007 and expressed a desire to stop his Depakote saying he felt better without it, so it was discontinued. His Seroquel was tapered off in 100 mg increments over 4 weeks (last dose 50mg) until discontinued, while he was started on Geodon and titrated up in 20 mg increments over 3 weeks to 60 mg.

He saw the same psychiatrist again for follow-up on March 29, 2007. At that time he complained of anxiety, and his leg was shaking. He mentioned a family history of cancer. Geodon 40mg am was added, continuing 60 mg pm. Risperdal was continued at 2mg HS.

On April 12, 2007, Inmate [Redacted] saw his case manager, and complained that he was depressed and the medications did not seem to be helping. From that point forward, the inmate had numerous clinical contacts, sometimes several in one week. At his next contact, April 19, 2007, he started talking about the fear that he might have cancer or AIDS, and requested a medical follow-up.

The medication Administration Record for April 2007 appeared to indicate that the inmate was often not showing up for medication. Medication compliance had not presented as an issue before this time. He was seen by a psychiatrist on April 23, 2007, and counseled about adherence to treatment. He was noted to be ambivalent about psychotropics, but willing to try just one medication. The Geodon was stopped, risperdone continued, Benadryl added.

He saw his case manager on April 26, 2007, an appeared stable at that time.

On April 29, 2007, the inmate told his case manager that he felt like he was dying of a disease, and was extremely anxious, hyper-vigilant, with excessive motor developments. He was immediately referred for a blood test that was performed "on the spot" to help reduce his anxiety about his medical condition. The case manager saw him again on May 3, 2007, and shared the results of his blood test, which were negative. The clinician noted that the inmate was somewhat unbelieving of the results at first, but seemed somewhat relieved. Some anxiety was still noted, but talk therapy was encouraged.

Notes indicate he also saw the case manager on April 20, 2007, after being referred by medical for anxiety, again purported to be due to his concerns about his medical condition.

* * *

[000264] State of California

Department of Corrections and Rehabilitation State of California

Memorandum

Date June 18, 2007

To Claude Finn, Warden
Tamara Robinson, M.D., Chief Medical Officer (A)
Anthony Coppola, M.D., Chief of Mental Health
Deuel Vocational Institution

Subject: Executive Summary of Suicide Report

A clinical review of this case found the following:

Name: ______________________

CDCR Number: ____________ Age: 29

Date of Death: March 9, 2007

Time of Discovery: 1515 hours

Location Of Death: West Hall Cell 238, Special Processing Unit

Mental Health Level of Care: Not in Mental Health Services Delivery System

Manner of Death: Hanging

Summary:

On Friday, March 9, 2007, Inmate ________, was discovered hanging in his assigned cell at approximately 1500 hours. Another inmate, newly arrived, had just come over from Receiving and Release and was assigned to the cell occupied by Inmate ________. The new inmate entered the cell, and the control officer closed the door. The new inmate noticed that a privacy sheet was hanging across a portion of the cell, and property was scattered across the floor. The new inmate looked behind the sheet, saw Inmate ___________ hanging, and immediately started kicking the door and yelling, "Man down! Get me out of here!"

The control booth officer opened the door and a floor officer entered the cell and pulled the sheet aside, observing Inmate ___ hanging from a sheet that was attached to the top of the cell window frame and affixed to his neck. The officer immediately activated the unit alarm and called for a cut-down tool. Staff responded and a sergeant lifted the inmate's body to take the weight off his neck, while another officer cut the sheet that was around the inmate's neck. The inmate was placed on the floor and pulled out of the cell. Officers placed him on a Stokes litter and started carrying him to the institution infirmary. Once outside of West Hall, they were met by a licensed vocational nurse with an electric gurney. The inmate was placed onto the gurney and rushed to the infirmary. Upon arrival, medical staff noted that the inmate was not breathing, and immediately called an outside ambulance and initiated cardiopulmonary resuscitation. A physician at San [000265] Joaquin County General Hospital pronounced Inmate _____ dead via telephone at approximately 1546 hours.

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[000266] ****

The inmate's Defense Attorney sought to have the inmate housed in a state hospital, either under the jurisdiction of the Department of Mental Health, or the Department of Developmental Services, pursuant to Penal Code 2684. Two complete psychological evaluations were conducted for the court's consideration. The conclusions were that he was severely mentally ill, but did not meet criteria for an insanity defense. He did not have a criminal mentality, and was rated as low risk for sexual offending on the Static 99. The recommendation was that he should be hospitalized rather than imprisoned; however, there was evidently no legal mechanism for this to occur.

Upon arrival at Deuel Vocation Institution Reception Center on March 5, 2007, Inmate ____ informed the registered nurse in Receiving and Release that he had a diagnosis of schizophrenia, and was taking medication (Zyprexa and Prozac) although no documentation arrived with him to support this. In fact, the "Confidential Medical/Mental Health Transfer" form from the Sacramento County Jail indicated no medications. The nurse wrote a "Request for Mental Health Services Staff Referral" chrono indicating undocumented medication, Prozac and Zyprex, "last dose two days ago." Staff indicated that typically they will try to verify undocumented medication if the inmate returns from a Parole Outpatient Clinic, but they do not follow-up with local jails due to lack of resources to do so.

The referral was received by mental health the next day, but no psychiatrist was scheduled to see the inmate with in 24 for a medication evaluation. The practice at this institution, developed when there was a shortage of psychiatrists, is for the screening to occur within 24 hours, and the screening clinician to refer to psychiatry at their discretion.

When Inmate ______ arrived at Deuel Vocational Institution, he was placed directly from Receiving and Release into the West Hall "Special Processing Unit", which is where "soft" protective custody inmates are housed as an alternative to administrative segregation. Within this unit, non-protective custody inmates also program, e.g. take meals there. Therefore, the cell doors are locked while the non-protective custody inmates are present in the common areas.

The following day, a social work intern went to see Inmate, and conducted the 31-item Brief Mental Health Screening through the cell door. That was his last mental health contact. The inmate was referred for further evaluation, scheduled for March 14, 2007.

When asked about her impressions of the inmate at the screening, the intern primarily focused on the fact that the cellmate, a rather intrusive individual, had at first refused to allow Inmate ______ to come to the door, and the intern was concerned that the cellmate was attempted to control Inmate ______. However, when asked if she thought the inmate's responses on the screening would have been different if she had seen him face to face in a confidential setting, she said she did not. When asked why the screening was not conducted outside of the cell, the intern's supervisor implied that custody staff was not cooperative with bringing inmates out due to the fact that they [000267] also program non-protective housing inmates in that area. The intern also reported that she had told custody staff she was concerned about the cellmate pressuring Inmate ______.

This reviewer sought to discover why the mental health screening was not conducted face to face in a private setting, as required by the Mental Health Program Guide. (It was the opinion of this reviewer that had the screening occurred in such a setting, most clinicians would have noticed his level of disability and hopefully the inmate would have been referred for an immediate evaluation and been seen by a psychiatrist. In this case, however, the inmate would not have had the opportunity to resume his medications until nearly two weeks after he had reportedly last taken them.) After further inquiry at the direction of the Chief Deputy, it became apparent that the mental health clinicians were not asking for inmates to be removed from their cells for interviews, in the interest of getting them done the day after their arrival to the institution (a local policy). If they had waited until the following day, or even perhaps come at a different time of day, the inmate could have been screened outside his cell.

Inmate ___________'s former cell mate reported that as soon as Inmate ___________ was placed into their cell, he started saying he needed his medication. Other inmates also said that Inmate _______ had asked a nurse for medication, and was told to "see the psych." The cellmate said that Inmate _________ was very religious, was crazy, was afraid of being in prison, and would not come out to shower. Inmate _________ reportedly kept telling officers that he needed to get out of the cell and tried at least four times to actually leave the cell with his property, but that the officers just put him back and told him to wait for courtesy moves on the weekend. Inmates reported they had no yard that week.

The cell mate also wanted a change. He asked officers at breakfast one Friday if they would be doing courtesy moves that weekend. He was told no because of TB testing. Therefore, he simply refused to go back into the cell. He was placed in Administrative Segregation for a few days, for refusing to rehouse with Inmate _______.

That afternoon, a new inmate was sent to house with Inmate _______ and discovered him hanging.

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[000269]

Identified Problem	Quality Improvement Plan	Required Supporting Documents
3. The mental health screening was conducted through the cell door, in front of the cellmate. The cellmate may have been pressuring Inmate ______, and may have influenced his responses. Furthermore, it is extremely difficult to observe an inmate while talking through the side of a solid door. This does not allow for adequate clinical assessment. The September 2006, Mental Health Program Guide mandates that all reception center mental health screenings and evaluations shall be conducted in a private confidential setting (September 2006 12-2-3.)	Clinical staff must conduct all mental health screenings in a confidential setting. The Chief Deputy indicated that custody will work with clinical staff to facilitate this, but clinical staff must make their needs known and be willing to work around program needs. A Quality Improvement Team is recommended for Deuel Vocational Institution to develop a process for both clinical and custody staff to follow to ensure that inmates are screened out of cell. Additionally, the local procedure must be updated.	Quality Improvement in Team charter, minutes, final recommendation, and outcome of recommendation.

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State of California

Memorandum

Date:

To: Michael Martel, Warden (A)
Brett Williams, M.D., Health Care Manager
Cyrus Moazam, Ph.D., Chief of Mental Health
Mule Creek State Prison

Subject: EXECUTIVE SUMMARY OF SUICIDE REPORT

A clinical review of this case found the following:

Name: CDC Number: Age: 34

Date of Death: 01/22/08

Time of Discovery: 2123 Hours

Institution: Mule Creek State Prison

Mental Health Level of Care:
Enhanced Outpatient Program

Manner of Suicide: Hanging

Summary:

On Tuesday, January 22, 2008, at approximately 2123 hours, during a security check of the first tier in the Administrative Segregation Unit in Facility C, Building 12, at Mule Creek State Prison, a correctional officer observed [Redacted], a 34- year old Caucasian male, hanging between the sink and the bunk, with a sheet tied around his neck and the other end of the sheet secured to the top bunk. The officer immediately activated his personal alarm and the control booth officer was notified via institutional radio of a Code One Medical Emergency. The emergency cell extraction team assembled, the inmate's cell door was opened, and the officers entered with caution. A clear protective shield was placed over Inmate [Redacted] and the cut-down tool was used to detach the sheet from the upper bunk. The part of the sheet around the inmate's neck was loosened and no longer obstructed his airway. Officers reported that the inmate's skin tone was described as pale and he was to the touch. Inmate [Redacted] pupils were fixed and dilated and he was incontinent of bowel and bladder.

The officers placed handcuffs and leg restraints on Inmate [Redacted] and removed his body from the cell. An officer started chest compressions for the cardiopulmonary resuscitation as a licensed vocational nurse began rescue breaths with the Ambu bag. An officer retrieved the Automated Electronic Defibrillator and the pads were attached to the inmate's chest. At approximately 2128 hours, the inmate was placed on a gurney by an officer and licensed vocational nurse. Cardiopulmonary resuscitation was continued while Inmate [Redacted] was transported on an electric

* * *

[4] Inmate [Redacted] was transferred from Mule Creek State Prison to the Correctional Treatment Clinic at California State Prison, Sacramento, due to increased psychotic symptoms and suicidal ideation. Records indicated that the inmate was relatively stable for the next two years.

A psychiatric report, dated January 11, 2006 noted that Inmate [Redacted] had been admitted to the Outpatient Housing Unit at Mule Creek State Prison after he came into the Treatment and Triage Area screaming that people wanted to harm him and demons were after him. At the time, the inmate was compliant with his medication, but symptoms of his mental illness appeared to be out of control. The inmate was then transferred to Correctional Treatment Clinic where he remained until December 12, 2006. The psychiatrist provided a diagnosis of Schizophrenia, Paranoid Type, and a Global Assessment of Functioning score of 35 (severe impatient).

On January 27, 2007, Inmate [Redacted] was brought to the Treatment and Triage Area due to acute stress, odd affect, delusions, and sad mood following a decrease in medication due to his desire to get off medication. He denied any thoughts of self-harm at that time and he was discharged. On January 30, 2007, the psychiatrist wrote the Inmate [Redacted] became angry over having his medication increased and asked that it be decreased. Psychiatry noted the inmate was "paranoid and blaming"

Inmate [Redacted] was placed in administrative segregation on June 7, 2007, for threatening a peace officer. A day later, a psychiatrist noted that Inmate [Redacted] wanted to taper off his medication and the inmate was monitored for a return of psychotic symptoms. Documentation by his case manager indicated Inmate [Redacted] missed his evening medications that caused sensitivity to heat. On June 29, 2007, Inmate [Redacted] was seen by his case manager again following a head-banging incident. He reported racing thoughts and being afraid of demons and presented as disorganized, paranoid, and delusional. He was placed in Mental Health Crisis Bed on June 29, 2007. He was removed from Suicide Precaution on July 2, 2007, and subsequently discharged.

During five-day follow up, his case manager noted that the inmate appeared to be fatigued, confused, delusional, and internally preoccupied, and he returned to the Correctional Treatment Center after three days. A medical report dated July 5, 2007, described Inmate [Redacted] as "crying a puddle of tears" earlier in the day, but he later exhibited angry, fearful affect. He again expressed fear of demons. Records indicate the inmate had been refusing his evening dose of Seroquel for two days. The discharge summary dated July 23, 2007, indicated that Inmate [Redacted] was selectively mute at the time of admission and shook his head positively when asked if he was suicidal. A foreign body was removed from his ear. Following a medication adjustment, he began responding verbally and when he was no longer suicidal, he was discharged back to his prior program. The inmate was given primary diagnosis of Schizoaffective Disorder and Borderline Personality Disorder. It was also noted that the inmate had an ear infection.

Progress notes in the unit Health Record indicated that Inmate [Redacted] become selectively mute from time to time and communicated with staff by writing notes. An undated letter written to the warden

* * *

[7] smile/grimace. The case manager consulted with the psychiatrist and noted the inmate would be evaluated for a possible Keyhea order.

Also January 10, 2008, at 0650 hours, the psychiatrist wrote an order that the inmate be weighed and results reported in the "vita signs" section of the Unit Health Record, to be repeated the first of every month for three months. On the same order, the psychiatrist wrote, "Please notify me in person or by note what IM's weight is today or tomorrow." There was no explanation for the charting of the inmate's weight. In fact, there were no progress notes in the Unit Health Record from the psychiatrist from November 13, 2007 until January 22, 2008.

On January 17, 2008, the case manager wrote that Inmate [Redacted] was selectively mute but responded to her questions by gestures. He denied thoughts of self-harm, but was vague about having thoughts of harming others, though he denied wanting to harm staff. The case manager thought the inmate was likely decompensated and wrote that she would again consult with the psychiatrist regarding the possibility of initiating a Keyhea.

On January 19, 2008, a correctional officer reported that Inmate [Redacted], while handcuffed, attempted to assault another inmate but was prevented from doing so when the officer grabbed Inmate [Redacted] and took him to the ground. On January 21, 2008 correctional officers conducted a pre-planned cell extraction after Inmate [Redacted] barricaded his door with a mattress, covering the window and the food port, and refused to respond to the request to cuff up and exit the cell. On January 22, 2008 the case manager reviewed and summarized recent behavior in her progress note and wrote that she discussed the case with the psychiatrist. Her plan was to "send I/M to TTA/CTC for evaluation for Keyhea process." The same day the licensed psychiatric technician wrote that he had initiated his personal alarm when Inmate [Redacted] attempted to push the cell door open against correctional officers who were closing it. After this incident, Inmate

[Redacted] was seen by both his case manager and psychiatrist together.

Later January 22, 2008, the case manager saw Inmate [Redacted] for a crisis evaluation. She wrote that Inmate [Redacted] outlined a conspiracy against him by racial bigots and stated he would hurt others to protect himself. When asked if he would take medication, the inmate stated he was not crazy and accused the case manager and the psychiatrist of being part of a racist hate group and conspiracy to harm him. The case manager reported that, "The I/M became increasingly agitated, screaming so hard spittle flew from his mouth." Although he had no suicidal ideation or intent, the inmate admitted to having thoughts of harming others to protect himself. Inmate [Redacted] adamantly refused Psychotropic medication and the plan was to have the psychiatrist admit the inmate to the Correctional Treatment Clinic and begin the Keyhea process.

On January 22, 2008, the psychiatrist wrote that he was asked to see Inmate [Redacted] who had exhibited increasing hostility, aggression, paranoia and delusional behavior. He reported that the inmate also told him that he would hurt people in order to protect himself and noted that the inmate became angrier the more he talked. The psychiatrist wrote that the inmate refused medication and stated he would fight everyone "including physically assaulting me". The psychiatrist noted there [8] was no restraint room available and he recommended starting Keyhea process in the morning when a bed would be available. The psychiatrist wrote that Inmate [Redacted] denied suicidal ideation but endorsed thoughts of harming others in order to protect himself. At approximately 2123 hours, Inmate [Redacted] was found hanging.

Although the case manager consulted with the psychiatrist about initiating a Keyhea protocol on three separate occasions during the last two weeks of Inmate [Redacted] life, it was never done. Both custody and mental health staff expressed shock that Inmate [Redacted] committed suicide. Based on his recent and continued aggressive and assaultive behavior, staff believed that Inmate [Redacted] was a danger to others but not a risk for suicide. It appeared that Inmate [Redacted] was not seen by a psychiatrist from November 13, 2007, until he was evaluated on January 22, 2008.

Several factors appear to have contributed to Inmate [Redacted] suicide. The Inmate [Redacted] returned to Mule Creek State Prison from the Department of Mental Health, California Medical Facility, Acute Psychiatric Program, on November 2, 2007, where he had been stabilized on medication prior to discharge. The inmate returned to the Administrative Segregation Unit at Mule Creek State Prison. He was not on a Keyhea order and decided to discontinue taking his psychotropic medication.

Within a month or so of being off psychotropic medication, Inmate [Redacted] began to show subtle signs of decompensation, but he was still stable. In January 2008, he learned that he would be going to court for assaulting a peace officer in August 2007. This stressful situation exacerbated his mental disorder and he begun to destabilize. On January 10, 2008, Inmate [Redacted] learned the assault was considered a second strike and he was sentenced to four additional years in prison. While he was out to court, Inmate [Redacted] attacked another inmate, apparently unprovoked, and received an additional Rules Violation Report for Mutual Combat. He was selectively mute from that point on until his suicide.

It seemed that the inmate continued to decompensate mentally and on January 19, 2008, Inmate [Redacted] attempted to assault another inmate, but was stop by a correctional officer who took him to the ground. This resulted in another Rules Violation Report for Resisting and/or Obstructing a Peace Officer resulting in the use of force. On January 21, 2008, Inmate [Redacted] barricaded his door with a mattress and correctional officers conducted a preplanned cell extraction. On the day of his death, January 22, 2008, Inmate [Redacted] attempted to push the cell door open against correctional officers who were closing it and an alarm was sounded. The psychiatrist and case manager saw Inmate [Redacted] and described him as agitated, delusional, paranoid, and threatening to the psychiatrist. Inmate [Redacted] adamantly refused psychotropic medication.

In the two weeks prior to Inmate [Redacted] death, the case manager consulted with the psychiatrist on three different occasions about the possibility of initiating a Keyhea order. Inmate [Redacted] was not considered a suicide risk and was not on Suicide Precaution. No suicidal gestures or attempts were noted in nearly three months since his return from the Department of Mental Health. However, after the suicide, shoes with laces were found in his property and one lace was removed from the shoe and appeared as though it may have been used for practice tying knots. Further, a piece of

* * *

[11] Identified problem	Quality Improvement Plan	Required Supporting Documents
2. On the day of the suicide, the restraint was not available and there was no other bed open in the Correctional Treatment Clinic. As a result, the inmate was left in his cell with no prescribed observation	Division of Correctional Health Care Services plans to open an additional 50 Mental Health Crisis Beds at the California Medical Facility on June 16, 2008. In addition, additional training will be provided to all staff through the monthly Suicide Prevention Videoconference regarding emergency placement options when no bed is available in Mental Health Crisis Beds.	Videoconference attendance sheets.
Inmate displayed increased hostility, aggression, paranoia, and delusional behavior on the last day of his life. Although the inmate had an extensive history of suicidal behavior, mental health staff did not consider the potential that his psychotic symptoms would create a heightened suicide risk.	Division of Correctional Health Care Services will provide additional training to all staff through the monthly Suicide Prevention. Videoconference regarding the connection between suicide risk and mental status.	Videoconference attendance sheets.

According to the Suicide Prevention and the Response chapter of the September 2006 Mental

Health Program Guide, the Quality Improvement Plan shall be implemented within 60 days of the date of the cover of this report. The designated institution or office is responsible for all recommendations as indicated. A final report of the completed Quality Improvement Plan and supporting documentation are to be submitted to Connie Hoglund, Ph.D., Senior Psychologist Specialist, Mental Health Programs, Division of Correctional Health Care Services (DCHCS), within 30 days of implementation (i.e, 90 days after the date of the cover of this report). The Warden, Health Care Manager and Chief of Mental Health must sign off on the final report.

Please understand that the Quality Improvement Plan report from each institution will subsequently be forwarded to the *Coleman vs. Schwarzenegger*, Item 7.b. "Defendants shall provide a copy of the report on implementation of a follow-up suicide corrective action plan to the special master's experts within 180 days from the completed suicide . . . "

State of California

Memorandum

Date: April 16, 2007

To: Suzan Hubbard, Warden (A)
Nadim K. Khoury, M.D., Chief Deputy Clinical Services
Victor Brewer, Program Director, Vacaville Psychiatric Program
California Medical Facility

Claude Firm Warden
Tamara Robinson, M.D. Chief Medical officer
Deuel Vocational Institution

Subject: EXECUTIVE SUMMARY OF SUICIDE REPORT

A clinical review of this case found the following:

Name: [redacted]:

CDC Number [redacted]:

Date of Death: January 27, 2007

Time of Discovery: 1445 Hours

Institution: Department of Mental Health Vacaville

Location Of Death: [Illegible]

Mental Health Level of Care: Acute Psychiatric Program

Manner of Death: Hanging

Summary:

Inmate-patient [Redacted] was a 19-year-old Latino male, who completed suicide on January 27, 2007, while housed in the Department of Mental

Health Acute Psychiatric Program at California Medical Facility. An order for one-to-one direct visual observation for the purpose of suicide watch was in effect at the approximately 1430 hours, Inmate-patient [Redacted] was smearing feces on his window and velling obscenities at staff. A medical technical assistant and senior medical technical assistant responded to the cell, and tried to talk to Inmate-patient [Redacted]. At approximately 1445 hours, when Inmate-patient [Redacted] did not respond, the senior medical technical assistant requested an extraction shield and opened the food port. The medical technical assistant holding the shield looked into the cell and saw that Inmate-patient [Redacted] was kneeling in front of his desk with a noose around his neck. The medical technical assistant activated his personal alarm. Thirteen medical assistants and one senior medical technical assistant were involved in lifesaving measures including retrieving the cut-down tool, simultaneously successfully removing the noose, which was made of a two-inch strip of the green safety blanket in the cell. Inmate-patient [Redacted] was removed from his cell and cardio-pulmonary resuscitation efforts began at cell front. Cardiopulmonary resuscitation continued until he was

* * *

[4] by mouth. He began to flood his cell, and was taken out to the day room. He spoke to staff about his concerns about being discharged to P-2. He agreed to cooperate upon return to his cell. When he returned to his cell at 1430 hours, he began to flood again, and smeared feces on the window. He continued to yell, until approximately 1445 hours.

[Identified problem	Quality Improvement Plan	Required Supporting Documents
The Department of Mental health administration requested to have 124 cells [to remove the desks and stools replace the beds, doors, and vent and window screens	The department of Corrections and Rehabilitation Facilities Management will seek Funding for the expeditious physical plant modifications, and will provide a schedule for completion of these physical plant modifications to the Coleman Court as soon as possible. see department of Mental Health Root cause Analysis Issue # 5	Log of modifications made and dates completed.
2. One-to one watch was not conducted appropriately on January 27, 2006. As soon as the inmate-patient could no longer be seen, the food port should have been shielded and opened for constant observation.	The Department of Mental Health will revise policies to specify that if an inmate-patient begins to cover his on her window, the response shall be activate an alarm immediately. See Department of Mental Health Root Cause Analysis Issue # 5	Revised policies from the Department of Mental Health
3. The response time to open the door may have been too slow. There is no time frame indicated between Inmate-patient [Redacted] failure to respond and the opening of the food port. Mitigating this problem is the fact that the sr. MTA bypassed standard Universal Precautions in order to intervene more quickly	The Department of Mental Health will revise policies regarding opening the food ports for the purpose of observation and emergency response see Department of Mental Health Root Cause Analysis Issue # 5	Revised policies from the Department of Mental Health

[5]Identified problem	Quality Improvement Plan	Required Supporting Documents
4. Suicide Precaution documentation indicated that Inmate-patient [Redacted] was observed every fifteen minutes. The intervals of observation were not staggered, and the documentation indicated very little	The department of Mental Health will revise policies regarding quality and time intervals for suicide precaution rounds. These policies will require increased interaction and staggered time intervals. see Department of Mental Health root Cause Analysis Issue # 13	Revised policies from the Department of Mental Health
5. Inmate-patient [Redacted] was able to use a safety "no-tear" blanket to create a noose.	The Department of Mental Health will research the availability of "no-tear" blankets that are more tear-proof, and will purchase alternate blankets if they are available. See Department of Mental Health Root Cause Analysis Issue # 9.	Department of Mental Health Audit of documentation for a sample of inmate patients discharged to the Enhanced outpatient Program.

* * *

[8] Identified problem	Quality Improvement Plan	Required Supporting Documents
13. Inmate-patient Redacted] remained at CCCMS level of care despite several Mental Health Crises Bed admissions from deuel Vocational Institution for the risk level indicated.	Deuel Vocational Institution shall develop a Quality Improvement Team to ensure all staff trained in suicide Risk assessment and documentation, using the training by Dr. Thomas white, before March 31, 2007. The quality Improvement team shall audit at least one Suicide risk assessment per [illegible], or create a peer Review for this purpose, shall provide follow-up training for any [illegible] determined by the audit.	Audit of suicide Risk Assessments completed by Deuel Vocational Clinicians
14. The Outpatient Housing Unit at Deuel Vocational Institution was used frequently, without referral to a Mental Health Crisis Bed, including for a serious suicide attempt on January 22, 2006. This problem is mitigated by the fact that Inmate-patient [Redacted] was sent to a Mental Health Crisis Bed three times while at DVI..	Deuel Vocational Institution shall refer inmate-patients who are repeatedly placed in Outpatient Housing Units or Mental Health Crisis Beds for [illegible] review teleconference at headquarters. A log of patients referred for clinical review including name, date referred, date of clinical review, and outcome shall be maintained for 60 days.	Log of inmate-patients referred for clinical review.

15. The Development Disability assessment on January 22, 2006 is inconsistent with all other reports of cognitive functioning. The chrono should not indicate an inmate is Normal Cognitive Functioning after he has already been identified as part of the Developmentally disabled Program.	Deuel Vocational Institution shall develop a Quality *Improvement* Team to ensure that no assessments for Development Disability are conducted without checking prior history	Report form the quality Improvement *Team* including methods of correcting the problem, and follow-up audits.

State of California

Memorandum

Date: April 20, 2007

To: Suzan Hubbard, Warden (A)
Nadim K. Khoury, M.D., Chief Deputy Clinical Services
Victor Brewer, Program Director, Vacaville Psychiatric Program
California Medical Facility

Robert Hernandez Warden
[Illegible]
[Illegible]

Subject: EXECUTIVE SUMMARY OF SUICIDE REPORT

A clinical review of this case found the following:

Name: [redacted]:

Age: 31

CDC Number [redacted]:

Date of Death: January 29, 2007

Time of Discovery: 1958 Hours

Institution: Department of Mental Health Vacaville

Location Of Death: [Illegible]

Mental Health Level of Care: Acute Psychiatric Program

Manner of Death: Hanging

Summary:

On Monday, January 29, 2007, at approximately 1958 hours, two medical technical assistants on unit

Q-2 of the Department of Mental Health Vacaville Acute Psychiatric Program noticed that Inmate-patient [Redacted] had covered the window of his cell door with a sheet. One medical technical assistant covered the food port with a Plexiglas shield while the other reached in and removed the sheet. They then saw that Inmate-patient [Redacted] was hanging at his door from a sheet that was around his neck. One of them activated his alarm and yelled, "we have a hanger" while quickly retrieving the cut down tool. He told two other medical technical assistants at the scene to prepare for entry, and they opened the cell door. Two of them lifted the body while the other cut the sheet above the inmate-patient's head, which was tied to the vent above the door. They then lowered Inmate-patient [Redacted] of the floor. One medical technical assistant detected a weak, irregular [illegible] and another medical technical assistant [illegible] assistants at the scene. They lifted the inmate-patient on to the backboard and then onto the gurney, and began to transport him to the B-1 clinic. Assisted breathing was continued and is pulse was monitored. As the transport team entered the elevator, the pulse was lost. One medical technical assistant climbed

* * *

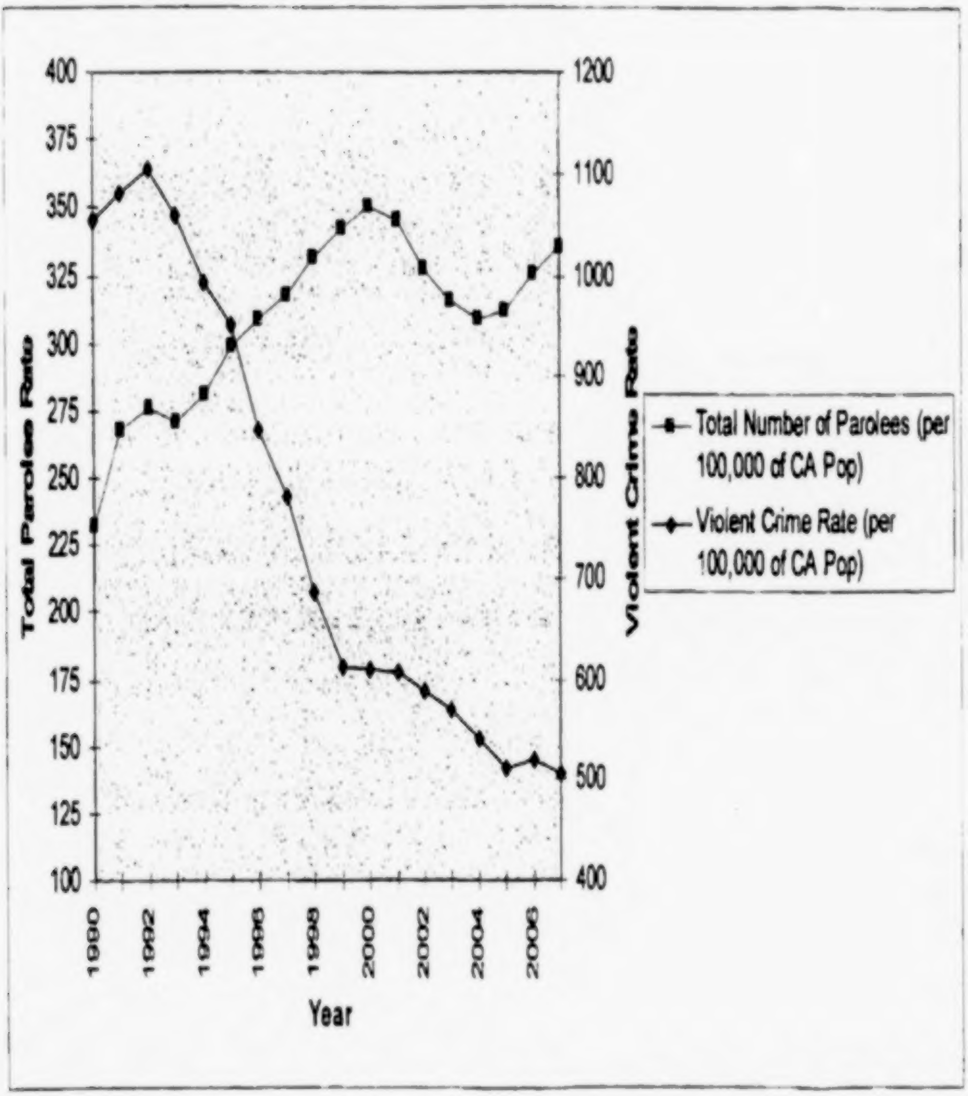
Identified problem	Quality Improvement Plan	Required Supporting Documents
9. When the inmate covered his window, staff had to obtain a shield and open the food port before they could see that he was hanging. This caused a slight delay in the emergency response.	The Department of Mental Health has already issued a memo instructing their staff to active alarm immediately in response to a patient commencing to cover his cell window. (See Department of Mental Health Root cause Analysis Issue # 5.) this will be incorporated into revised policy	Copy of memo and/ or revised polices, and evidence of training.
10. The Department of Mental Health has been attempting to have the vents retrofitted in patient rooms since the last hanging in December 2005. The California Department of Corrections and Rehabilitation must facilitate the physical plan modifications requested.	The California Department of Corrections and Rehabilitation shall expeditiously seek funding to retrofit patient rooms including modifications to vents, doors, beds, desks and stools, to minimize opportunities for easy access to self-harm behaviors. (see Department of Mental Health root Cause Analysis Issues #6 and 7)	Descriptions of the work done including timelines for completion, and photographs.
11. When emergency equipment is in use, there are no back-ups in case of concurrent emergency situations.	The Department of Mental Health shall ensure that emergency equipment is available and maintained in a standardized locations, with procedures in place to ensure accountability. See Department of Mental Health Root cause Analysis Issues #6 and 7)	Documentations of policy and training.

[Identified problem	Quality Improvement Plan	Required Supporting Documents
12. The primary therapeutic modality provided in the Acute Psychiatric program is medications management. This does not address co-morbid Axis II disorders, which are seen with increasing frequency.	Department of Mental Health will train staff on current methodology and intervention for treating Axis II diagnoses. Additionally, they will utilize a "positive Behavior Support Team" to helf staff understand the functions of "manipulative behaviors, and make specific recommendations for therapeutic interventions incorporated into the overall treatment plan. (See Department of Mental Health Root Cause Analysis issues #9 and 10.)	Documentations of policy and training.

California

Parolees and Violent Crime Rate

1990-2007

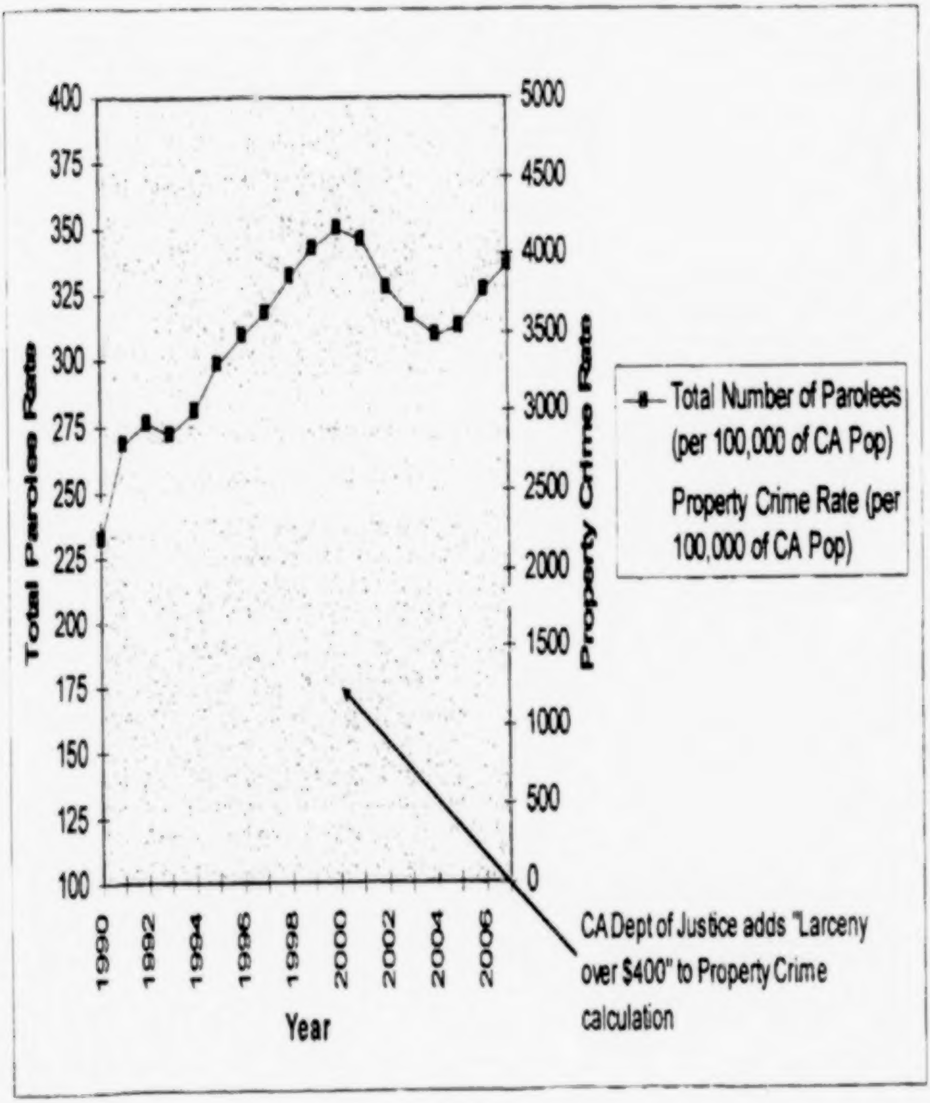


Case No. CIV S-90-0520 LKK JFM P (E.D. Cal)
C01-1351 TEH (N.D. Cal)
PLTF Exhibit No. P-842
Date Entered ________________
Signature ________________
Alternate Reference

California

Parolees and Property Crime Rate

1990-2007



[1] UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
450 GOLDEN GATE AVENUE
SAN FRANCISCO, CALIFORNIA 94102

THELTON E. HENDERSON
SENIOR UNITED STATES OF DISTRICT JUDGE

May 22, 2008

VIA ELECTRONIC MAIL AND U.S. MAIL

Senator Michael J. Machado
State Capitol, Room 5066
Sacramento, CA 95814

Re: *Senate Bill 1665*

Dear Senator Machado:

Thank you for sponsoring Senate Bill 1665, which provides full funding for the construction program set forth in the *Plata* Receiver's strategic plan.

I understand that support for SB 1665 may be wavering with this week's news recording a possible settlement of the proceedings before a three-judge court, of which I am a member, concerning prison overcrowding. Those proceedings concern whether overcrowding is the primary cause of the unconstitutional nature of medical and mental health care delivery to inmates. Although no settlement has yet been presented to the judges for their approval, and I therefore do not know the terms under consideration, resolving the overcrowding issue would only remove one barrier to achieving the delivery of constitutionally adequate health care to inmates. Without more, a reduction in prison overcrowding will not ensure that the delivery of medical health care to California's inmates will reach constitutional standards. Thus, without more, a settlement to reduce the prison population will not address the core issue in *Plata*, nor will it alleviate the reasons for the Receivership and my oversight over the prison's medical health care delivery system. Instead, a reduction in the prison population would simply resolve the plaintiffs' argument that overcrowding is the primary cause of the constitutional violations.

In addition, as you may know, three other federal district court judges and I are coordinating our efforts in four statewide prison class action lawsuits over which we individually preside. These cases concern medical health care (*Plata*), mental health care (*Coleman*), dental care (*Perez*), and disability access issues (*Armstrong*) in California's prisons. As the attached order demonstrates, the three other judges and I have approved an agreement for my Receiver to take the lead on prison construction projects, including the plan under consideration to construct new health care facilities that will serve the needs of up to 10,000 inmates. I have been briefed on [2] numerous occasions concerning the proposed construction program, as set forth in SB 1665, and I believe strongly that the program—particularly in the phased fashion in which it will be undertaken—represents an appropriate, cost-effective plan that will address the major treatment and housing concerns in all four federal class actions.

I appreciate that SB 1665 asks for a significant amount of funds, but please rest assured that I am extremely concerned about spending funds from the public fisc in an efficient manner. To that end, I will not permit my Receiver to continue to undertake a construction program that becomes unnecessary due to changed circumstances, including any future reductions of the prison population in such a way that eliminates the need for additional medical facilities. My Receiver has made a similar commitment to me that he will carefully evaluate the need for additional facilities on a phase-by-phase basis.

In light of all of the above, I hope you will continue to communicate with your colleagues about the urgency of passing SB 1665. I have directed my Receiver to continue working with you and other members of the Legislature to ensure the bill's expedited passage.

Sincerely,

/s/ Thelton E. Henderson
Thelton E. Henderson

Enclosure (February 26, 2008 Order Approving Construction Agreement)

cc: (without enclosure and via electronic mail only)
J. Clark Kelso, *Plata* Receiver
Paul Mello, counsel for *Plata* Defendants
Donald Specter, counsel for *Plata* Plaintiffs

* * * *

Report of David L. Thomas, MD JD

I. Name and Address of Expert

David L. Thomas, M.D., J.D.
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Professor and Chairman, Division of Correctional Medicine
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II. Addendum to Statement of Opinions and of the Bases and Reasons Therefore

1. On December 6, 2007, I had the opportunity to fly to California to evaluate several California Department of Corrections and Rehabilitation facilities. These included San Quentin State Prison, the California Medical Facility and California Institution for Men. During this evaluation I had the opportunity to observe daily and weekend functions of the prison and medical facilities, talk to staff, inspect medical records, interact with physician providers, nursing staff and correctional officers. I was also able to witness pharmaceutical functioning, direct care delivery including triage, chronic illness clinics, acute care response, individual provider interactions and system functioning.

Report of David L. Thomas, MD JD

I. Name and Address of Expert

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Professor and Chairman, Division of Correctional Medicine
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II. Addendum II to Statement of Opinions and of the Bases and Reasons Therefore

1. On September 1, 2008, I had the opportunity to fly to California to evaluate several California Department of Corrections and Rehabilitation facilities. These included North Kern State Prison, the Substance Abuse Treatment Facility, Pleasant Valley State Prison, California State Prison in Solano, and High Desert State Prison. During this evaluation I had the opportunity to observe daily functions of the prison and medical facilities, talk to staff, talk with inmates, inspect medical records, interact with physician providers, nursing staff and correctional officers. I was also able to witness pharmaceutical functioning, direct care delivery including triage, chronic illness clinics, acute care response, individual provider interactions and system functioning.

[2] 2. Prior to traveling to California I had the opportunity to review the material sent to me including the reports of Dr. Craig Haney, Pablo Stewart, reports of the receiver to the court (Turnaround, 7th and 8th), several internet web sites concerning individual prisons as well as the California Department

of Corrections and Rehabilitation and several other various items.

* * * *

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Expert Report re:
Coleman et al. v. Schwarzenegger et al.

Ira K. Packer, Ph.D., ABPP (Forensic),
December 10, 2007

Referral issue:

I was retained by the State of California in reference to the plaintiffs petition (in *Coleman et al. v. Schwarzenegger et al.*) for a prisoner release based on the finding that the State has not remedied the deficiencies in delivery of constitutionally adequate services to mentally ill inmates. I have been asked to address the issues of whether: (1) crowding is the primary cause of the violation of the Federal right; and whether (2) no other relief will remedy the violation. I submitted a preliminary report on November 8, 2007. This represents my final report, based on review of materials (as noted below) as well as my tour of prison facilities between November 26-30, 2007 (as documented below), which included interviews with inmates, mental health staff, as well as correctional staff.

Documents reviewed:

- Declaration of Deborah Hysen, May 24, 2007
- Declaration of Margaret McAloon, Ph.D., May 24, 2007
- Declaration of Kathryn P. Jett, May 24, 2007

- Declaration of Doug McKeever, May 24, 2007
- Declaration of Joan Petersilia, Ph.D., May 24, 2007
- Declaration of Scott Kernan, May 24, 2007
- Memorandum re: Out-of -state correctional facility program, Phase III, February 2,2007
- [2] Memorandum re: 3001 Penal Code Compliance Policy Statement, May 15, 2007
- Summary Monthly Report of CDC patients in DMH hospitals, May - August, 2007
- Report on Suicides Completed in the California Department of Corrections and Rehabilitation in Calendar Year 2005, Raymond F. Patterson, M.D.
- Defendant's plan to address suicide trends in administrative segregation units, October 2, 2006
- Memo re: Administrative Segregation Unit 30 minute welfare check, August 6, 2007
- Court order to implement plan to reduce suicide in administrative segregation, February 9, 2007 (Judge Karlton)
- Special Master's Supplemental Report and Recommendations on defendant's plan to prevent suicide in administrative segregation, May 14, 2007
- Court order accepting Supplemental Bed Plan, October 17, 2007 (Judge Karlton)
- Special Master's Report on Plaintiffs Response re: Salary Enhancements, January 30, 2007

- Court order regarding pay parity, May 23, 2007 (Judge Karlton)
- Defendant's redacted response to court order of May 23, 2007 re: pay parity plan
- Court order regarding pay parity, June 28, 2007 (Judge Karlton)
- Court Order regarding proposed coordination agreements in the areas of information technology, credentialing, hiring, and pharmacy, May 29, 2007.
- Court Order approving coordination agreements, June 28, 2007
- Governor's Prison overcrowding state of emergency proclamation, October 4, 2006
- Special Master's Report on Enhanced Outpatient Treatment Programs in Reception centers, August 15, 2007
- Special Master's Response to Court's May 17, 2007 Request for Information, May 31, 2007
- Special Master's Report and Recommendations on Defendant's August 2007
- Supplemental Bed Plan, September 24, 2007
- [3] Defendant's Opposition to Plaintiffs' Motion to Convene a Three-Judge Panel to Limit the Prison Population, December 4, 2006
- Reporter's Transcript of hearing on December 11, 2006 re: Plaintiff's motion to convene a three judge panel
- Defendant's Supplemental Brief in Opposition to Plaintiffs' Motion for Referral to a Three-Judge Panel, May 24, 2007

- Court order to convene a 3 Judge Panel, July 23, 2007 (Judge Karlton)
- Supplemental Bed Plan Report, August, 2007
- Small management yard plan, October 25, 2007
- MHSDS Program Guide
- Receiver's Supplemental Report re: Overcrowding dated June 11, 2007
- The Summary sections of the Special Masters Monitoring reports -15th report (1/23/06) and 16th report (12/13/06)
- Receiver's Plan of Action, November, 2007 (with a focus on the Information technology section)
- Proposed Chapter XI of the Program Guide (referencing transfer of CCCMS inmates to out of state facilities) dated 10/23/07 (draft)
- Annual Suicide Report for 2006
- Corrective Action Plan (CAP) for California State Prison- Sacramento (SAC), October 29, 2007
- Staffing Pattern for SAC, October, 2007
- Appendix B (case reviews) to report of suicides in 2005
- CIM *Coleman* Site Visit Program Summary, October 10, 2007
- CIM *Coleman* CAP, October, 2007
- Transcript of a monitoring tour exit call from Richard J. Donovan Correctional Facility on November 20, 2006

- Revised Reception EOP Plan, December 3, 2007
- Defendant's Response re: Small Management Yards, December 4, 2007
- Declaration of Joseph Moss in Support of Defendant's Response to Notice of Non-Compliance Re: Small Management Yards, December 4, 2007
- [4] Review of Plaintiffs expert reports by: Craig Haney, Ph.D., Pablo Stewart, M.D., and James Austin, Ph.D.

Prison facilities toured:

Between November 26-30, 2007, I toured the following prison facilities, which included interviews with health and mental health staff and administrators, correctional officers and administrators, interview of inmates (at both the CCCMS and EOP level) who were chosen randomly, and review of randomly selected charts. During these tours I was accompanied by attorneys for the plaintiffs, attorneys for CDCR (and, for the last day, an attorney from the Attorney General's office), as well as representatives from CDCR headquarters.

- California Medical Facility (CMF) – Vacaville, November 26, 2007 (including DMH units)
- California State Prison – Sacramento, November 26, 2007
- Valley State Prison for Women (VSPW), November 27, 2007
- Central California Women's Facility (CCWF), November 27, 2007

- Salinas Valley State Prison (SVSP), November 28, 2007 (including DMH units)
- California Institution for Men (CIM), November 29, 2007
- R. J. Donovan Correctional Facility, November 30, 2007

Qualifications of expert:

I have attached my curriculum vitae which provides information about my professional qualifications. In terms of specific expertise relevant to this assessment, I would highlight the following aspects of my experience:

I am a Board Certified Specialist in Forensic Psychology (from the American Board of Professional Psychology) with over 28 years experience in forensic and correctional psychology. I have worked in maximum security forensic hospitals whose populations included prison inmates. My first such experience was at the Center for Forensic Psychiatry in Michigan (1979-1985), a Department of Mental Health facility, which included units for transfers from the state prison. I also worked for 6 years (2001-2007) [5] at Bridgewater State Hospital in Massachusetts, a Department of Correction facility, which provided evaluations and treatment for, among others, state prisoners. At that facility I served as the Director of Forensic Services as well as Chief of Psychology. I was a member of the Hospital Executive Committee; this leadership committee developed and implemented policies and procedures, and was responsible for coordinating the successful attempt to obtain JCAHO accreditation for that facility (obtained for the first time in the facility's history in 2003) as well as re-accreditation (2006). A significant policy change which we implemented clarified admission and discharge criteria for prisoners, tightened the procedures for screening and triaging admissions, and improved communication between the hospital and the prisons.

I also was involved in program development, policy development, and operational implementation of mental health services to the 18 Massachusetts Department of Correction prison facilities. From 1998-2001, I served as Deputy Mental Health Program Director, during which time significant improvements were made in the delivery of mental health services to inmates in the Massachusetts prison system. From 2001-2007, as noted above, I served at Bridgewater State Hospital, but also maintained responsibility For oversight of the psychologists in the prison system (as Director of Psychology).

In addition to my experiences in the prison system, I also have extensive experience with county correctional facilities. From 1985-1993, I was program director for a community forensic program in Western Massachusetts, which included provision of services to the local courts as well as to three County Correctional facilities. In that capacity, I was responsible for development of a mental health program at the Hampden County Correctional Center, which has served as a model for other facilities in the Commonwealth. During that time, I also provided direct clinical services at the facility. During the later years of this period, we provided mental health services in an overcrowded facility, which was subject to court monitoring (unrelated to the mental health program), pending building of a new facility.

[6] I also served, from 1993-1996 as Assistant Commissioner for Forensic Mental Health in the Massachusetts Department of Mental Health (DMH). In that position, I was responsible for oversight of forensic mental health services to over 70 courts, as well as to 13 county correctional facilities. During my tenure, we developed standards for evaluation of quality of services at these facilities. In addition, we initiated a new program called the Forensic Transition Team (FTT). This service was developed in response to concerns that mentally ill inmates were being discharged from the prisons and county correctional facilities without adequate community services in place. The FTT program involved Department of Mental Health clinicians working with inmates and the facilities prior to discharge to ensure a coordinated plan in the community. FTT clinicians work with the newly released inmates for a period of several months until care can be transitioned to DMH case management and/or community providers. This program has been very successful and was recently significantly expanded.

Note on Methodology:

This report is based on my review of the documents listed above, augmented by information obtained during my visits to the facilities. I interviewed approximately 20 inmates and also reviewed a number of charts. I utilized the information I obtained on-site to either corroborate or raise questions about data contained in the documents I reviewed, and/or to direct me to obtain additional information. I also attempted to corroborate, whenever possible, information obtained from inmates. In most instances, their reports were consistent with other sources of information (but not always so). To the extent that I utilize statements from staff and inmates in this report, this is done to illustrate a point, rather than as evidence of a particular practice. I believe this is an important caveat, since the aim of this assessment is to identify the primary cause of system deficiencies, which cannot be done on an anecdotal basis.

[7] Also, to provide a context for this report, the high prevalence rates of mental illness in prisons is a national phenomenon, not limited to CDCR.[1] Many of these individuals enter prisons with a history of mental illness. Prisons were not designed with this population in mind, and prison environments, whether overcrowded or not, are not conducive to the treatment of mental illness. Furthermore, many of the mentally ill inmates in prisons present not only with psychiatric disorders but also with antisocial traits, making them particularly difficult to treat. Prisons have been required to develop mechanisms to provide treatment, without compromising security. For instance, CDCR and some other jurisdictions employ what are called "Treatment Modules" to provide group therapy to inmates requiring high levels of security (such as in ad-seg units). These modules are booths, which are designed to allow the inmates to see and hear each other and the group leader, but prevent any direct contact. Although a neutral observer may be taken aback when first seeing these modules, the alternative (as in Massachusetts, which does not employ them) is simply not

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[1] For example: James, D.J. & Glaze, L.E. (2006). Mental health problems of prison and jail inmates. *Bureau of Justice Statistics*, Special Report, Sept. 2006; Pinta, E.M. (1999). Meta-analysis of prison mental health studies. *Correctional Mental Health Report*, p. 33.

to provide any group treatment to such inmates. 1 point this out as an example of the need to evaluate the mental health services in CDCR within the context of appropriate treatment in a prison environment, as opposed to treatment in community settings. My opinions expressed here thus reflect my assessment of the problems preventing CDCR from providing adequate mental health services to the *Coleman* class within the context of a prison environment.

Although I interviewed a number of inmates/ patients, I did not record their names (referring to them in my notes only by the first initial of their last name), in order to preserve confidentiality and privacy as much as possible. However, the plaintiffs' attorneys who accompanied me did record their names and prison i.d. numbers, so they have the opportunity to corroborate or disconfirm points made in my report based on those interviews.

[8] Scope of opinion:

I am addressing the impact of overcrowding specifically on the *Coleman* class, which includes inmates with "serious mental disorders." My assessment incorporates the following determinations which have been presented in the various documents, and which I am not independently evaluating:

1. The California Prison system is overcrowded, as there are currently approximately 173,000 inmates in CDCR facilities.
2. The Court has determined that CDCR's provision of mental health services is not in compliance with Constitutional requirements (8th amendment).

Thus, the question is whether the overcrowding is the primary cause of the lack of compliance and whether compliance can be achieved by means other than an order for prisoner release.

Based on my review of the documents above, it is my professional opinion that the overcrowding in CDCR significantly contributes to the difficulties in providing adequate mental health services, but is not the primary cause of the deficiencies. In my professional opinion, the lack of adequate intensive mental health treatment beds (EOP, Mental Health Crisis Beds, Acute Psychiatric Hospital Beds, Intermediate Care beds) is the primary cause of the deficiencies in providing mental health care to mentally ill inmates in the CDCR. However, this is not primarily a function of the large population in the prisons (as the number of mentally ill patients is not simply a fixed percentage of prisoners, but is primarily impacted by factors that lead to the mentally ill being disproportionately incarcerated). Rather, the lack of sufficient beds and resources at the "high end" of the mental health system in the CDCR reflects both the unanticipated influx of mentally ill prisoners into the correctional system over the past 2-3 decades, and the delay in the state's response to this situation. Only more recently has the state undertaken a more comprehensive and planful approach to this issue (as evidenced by the [9] development of the strike teams, the new bed plan and other responses to recent court orders).

As noted above, the increasing numbers of mentally ill individuals becoming incarcerated is a national problem, likely attributable to a number of causes (including lack of adequate mental health care in the community, lack of access to such health care for many vulnerable individuals, and other factors unrelated to the prison system). These factors impact the California system, which is also plagued by a high number of parole violators (including many who are mentally ill) being returned to prison, discussed below on the section on Reception Centers. Focusing on a prisoner release is thus likely to provide only a modicum of relief to the problems in providing services to mentally ill inmates; the main efforts need to be directed specifically towards programming and resources for this vulnerable population.

The sections that follow represent specific analyses of a number of the most significant issues impacting mental health care in the CDCR. For each issue, I present my opinion as to whether overcrowding is the primary cause of problems noted and, if so, if there are alternatives to a prisoner release that could remedy the situation.

Lack of beds and treatment space

My observations corroborated the documentation that indeed there are not enough beds available for mental health programming at the highest levels of intensity, including Mental Health Crisis Beds (MHCB), EOP program beds, and acute and intermediate care DMH beds. I have reviewed the Declaration of Deborah Hysen (May 24, 2007) regarding the Facilities Construction Strike Team's plans for increasing bed and programming space, the Supplemental Bed Plan developed by CDCR in August, 2007, as well as the Special Master's report noting the use of mobile trailers to increase programming space. It is my opinion that these strategies, if properly implemented, can reasonably be expected to ameliorate the problems posed by the current lack of an adequate number of beds at the higher levels of mental health care.

[10] The completion of the construction projects, though, is several years away. In the interim, one of the strategies has been to convert existing space for use with these populations (retro-fitting). However, the effectiveness of this strategy is limited by the fact that existing space was not designed to serve the functions required for these units. A good example of this problem was noted at Salinas Valley (SVSP), where there is both a free-standing DMH building, as well as intermediate care DMH units in the D building of the prison. The differences in the units is quite striking, as the free-standing building has a therapeutic "feel" to it, appears designed to provide therapeutic services, and has reasonably adequate space to provide those services. By contrast, the unit in the D-building (which has been designated as temporary space) is standard prison unit, without adequate space for treatment, and difficulties in providing confidential 1:1 treatment environments. The problem is not with the census in the unit, but rather that the space is not appropriate for the purposes of providing intermediate care treatment to mentally ill inmates. Similarly, the EOP ad-seg unit which I visited at SVSP (for example) was also using retrofitted space, and had similar problems. Groups (using Treatment Modules) are run in the laundry room, which is a non-therapeutic milieu. The difficulties posed by using existing spaces in a manner not consistent with its original design are not limited to SVSP. The issue of overcrowding is not the cause of this problem, and a reduction in the number of inmates in the CDCR would not solve this problem. Rather, the most appropriate solution appears to be the one being pursued - construction of mental health units designed for that function. In some situations (such as SVSP), mental health staff and administra-

tors reported that they have requested to move the existing unit to another building, with better space, which would provide better accommodations for both group and individual work. To the extent that such resources can be identified, this would represent an improvement over the current arrangement, pending the new construction.

EOP beds

In terms of other issues related to efficient use of existing resources, some of the earlier documents suggested difficulties in utilization management (that is, patients staying too long in higher level beds, such as DMH beds and crisis beds), thus creating lack of beds [11] for other patients who need them. I have been impressed that good progress has been made in this area. For instance, Vic Brewer, of DMH informed me that the length of stay (LOS) in the DMH intermediate care beds is now approximately 8 months, down from 16 months a couple of years ago (and right within the expected LOS of 7-9 months). Similarly, mental health staff provided me with reasonable explanations for some EOP inmates being maintained for long periods of time in that program, rather than being returned to GP. They explained that these are clinically driven decisions (in that some individuals are simply not capable of ever functioning well in GP, but do quite well in EOP, and do not require a higher level of care). For these individuals, prolonged stay in EOP programs is the clinically appropriate response and does not reflect a census problem or a systems failure. Indeed, one of the women I interviewed exemplified this point well, as she had a history of abuse and depression, was able to function reasonably well within the sequestered EOP program, but did not feel that she could tolerate the additional demands of a GP setting.

However, it is also clear that some inmate patients remain in EOP units pending transfer to DMH units. The system is "clogged" in the sense that the higher intensity beds are usually full, creating long waiting lists at other levels. As noted above, this is not an issue related to overcrowding in general (that is, not primarily a function of the total number of incarcerated inmates), but rather is primarily a function of the lack of adequate beds and programs for the most seriously mentally ill. Even if the total census of the prisons were to be reduced, there would still likely be a need for more EOP beds as well as other programming for mentally ill inmates (as discussed below).

Mental Health Crisis Beds

Another identified area which has a shortage of beds is the mental health crisis beds. These are being addressed in the supplemental bed plan. In the interim, the shortage of crisis beds is problematic as inmates requiring more intensive observation and/or treatment must remain in other settings, which are not clinically appropriate. This problem is more acute in some facilities than others. For instance, some of the facilities I visited did not have all the crisis beds filled, some (like R.J. Donovan) have an overflow [12] unit (which is not licensed), which they have used for those not considered acutely suicidal, but which has not been used often recently. However, in SAC, one inmate was being "housed" in a "ZZ" booth in a passageway, monitored by an officer. He had been there over the long Thanksgiving week-end. I was informed that this was not a common occurrence, but did occur at times when the other beds were filled. This is clearly not an acceptable standard of practice.

However, given the alternatives which are available for observation of such individuals this is a problem which could be addressed by better management, including increasing the recognition that such an arrangement is never acceptable and requires immediate response, even on a holiday or week-end. In terms of alternatives, for instance, SAC has additional beds in an OHU and MHOHU, and there is a process for transferring to crisis beds in other facilities. Although all the beds in OHU and MHOHU are filled before the "ZZ" cells are employed, in such situations a triage process, either at a facility or central level, should be undertaken, to free up an appropriate observation cell for such an inmate.

In terms of the crisis bed issue - some facilities use their unlicensed OHU's as an alternative or precursor to the crisis bed. From my observations, this does not necessarily reflect a less desirable practice. I was repeatedly informed that many of the individuals so observed were deemed not to be in genuine mental health crisis and could be treated and managed appropriately without taking up a high intensity crisis bed. I have experience working in correctional facilities that indeed used such observation cells (for 1-2 days) as a means of determining whether the individual truly required a crisis or hospital bed. As long as this system is used based on clinical judgment, with an understanding that those deemed in imminent crisis (such as the system described to me at R.J. Donovan) must go directly to a licensed bed, this would be considered a reasonable practice.

DMH beds

Consistent with the documents reviewed, during my tour of the facilities staff confirmed that there is often a long waiting list for DMH beds, resulting in patients remaining either in crisis beds or in EOP level of care. Again, this is not a reflection of the general issue of crowding, but rather the need for more higher intensity beds, which will be addressed by [13] the bed plan. However, an additional issue relates to some difficulties between the agencies (CDCR and DMH) in terms of determining when an inmate is appropriate for DMH care. A number of staff reported that they had difficulty getting DMH to accept some patients who were considered to be high security. Although I am not in a position to judge the validity of DMH's concerns, the solution to this problem requires higher level administrative intervention (at a level higher than either CDCR and DMH), and is not primarily related to crowding.

In terms of space issues for DMH beds, it is clear that space designed specifically for the purpose of providing licensed mental health care is much more effectively used than retrofitting existing prison units. The latter is a necessary stop-gap measure, but is not a long-term solution. Thus, even if more prison units were to be available for use as mental health units as a result of a prisoner release, this would not be a good alternative to the current plan to build newer facilities (which is underway, as I observed).

Access to yards

Another space issue identified by the Special Monitor and acknowledged by CDCR relates to design problems that limit the opportunities for inmates in ad-seg to go out to yard. I reviewed the Small Management Yard Plan submitted by Ms. Hysen (October 25, 2007), and in my opinion, this represents a reasonable approach to this problem and would serve to improve conditions for mentally ill inmates in administrative segregation. During my tours I viewed some of these yards and they do provide a means to increase the out-of-cell time for these individuals, which is a significant issue in particular for mentally ill inmates. The ability to utilize these yards maximally is limited by shortages in custodial staffing (which is directly related to overcrowding). I understand that the CDCR has proposals for increasing its recruitment of correctional officers. It is beyond my expertise as a mental health professional to comment on whether these plans will succeed in recruiting sufficient officers to address this problem.

[14] Lack of adequate staffing:

I have reviewed the State's pay parity plan to increase the salaries of mental health professionals. This plan appears reasonable and is likely to increase the number and quality of professional staff willing to work within the prison system. (I would also note that the plan was amended to increase pay for DMH staff, in anticipation that failure to do so would likely result in DMH staff transferring to CDCR. This speaks to the likelihood of the pay parity plan being successful in recruitment and retention). During my tours I was informed by administrators (and this was confirmed in the documentation that I reviewed) the pay raises have helped significantly with recruitment of mental health staff. I also met a number of psychologists, for example, who had recently been hired as a result of the pay increases. The pattern with psychiatrists was more mixed, as some areas of the state have been more successful than others. I was also informed that parity raises for nurses has not yet been implemented, a strategy that would likely help improve that situation. Some of the facilities have filled their vacancies with contract staff, which is less desirable than permanent staff, due to turnover. To the extent that the state can develop longer term arrangements (that is for a longer minimum length of service) with contractors, this would be desirable. For example, in some facilities I was informed that some contractor staff have been there for many years and thus function, for all practical purpose, in the same capacity as permanent employees.

A general reduction in the prison population is unlikely to have a significant impact on the size of the *Coleman* class and the need for mental health professionals to provide services to this class. As mentally ill inmates constitute approximately one-fifth of the population, a general reduction of census would, at most, result in reduction of one *Coleman* class inmate for each five inmates released. Even if there were to be a reduction of *Coleman* class inmates within each institution, this would not necessarily translate into a real ability to redeploy staff resources across institutions, due to issues of geography and patient needs. Thus, if there is decreased need for mental health staff in a particular institution (e.g., due to a smaller number of CCCMS inmates), this does not necessarily mean that these staff can be deployed in other institutions which may be in a different part of the state, or that these staff are best suited for working in different settings.

[15] The staff shortage issue is more prominent on the custodial side. In some parts of the state, there continue to be difficulties in hiring and maintaining adequate correctional staff, which is primarily a function of the census. Although this is a significant problem which impacts the prison system in general, it is not, in my opinion, a primary cause of problems

in mental health service delivery for the most impaired inmates. The CDCR model of classifying mentally ill individuals by level of severity and providing, for the most part, separate services and housing for the EOP population, in many ways insulates these individuals from the consequences of this problem for the general population inmates. There is some impact in terms of access to yards being limited at times when correctional staff are stretched thin, but across all my tours (and review of documents), it does not appear that programming for EOP inmates is detrimentally impacted.

The shortage of correctional officers does appear to have more of an impact on CCCMS inmates, who are housed in General Population and may experience difficulties in movement (to yard and to appointments, as well as to groups). In some facilities I visited (for example, CIM), mental health staff reported that it was difficult to run groups for CCCMS inmates due to other demands on officers. However, the staff did not report difficulties in providing individual services even in those facilities. Furthermore, the difficulties in providing treatment were not simply a function of lack of officers; for example, some of the gangs forbade their members to attend groups or to participate in treatment, an issue unrelated to staffing shortages or census issues.

Similarly, significant problems in delivering services to CCCMS patients were noted at SVSP, C-yard. This yard houses some of the most violent inmates, including many with gang involvement. This results in very frequent lockdowns on those units, which prevents groups from occurring. The frequent cancellations of such groups makes them almost useless for these CCCMS inmates. However, the mental health staff I interviewed reported that they were not hampered in their ability to see their clients individually. They also did not report a pattern of a large number of their CCCMS clients decompensating and requiring higher levels of services.

[16] I interviewed a Captain on the C-Yard and he insisted that even if there were fewer inmates in his facility, he believed the problems would persist because of the high violence level of this particular class of inmates. I cannot comment on whether the frequent lockdowns represent a strategy imposed by the lack of a sufficient number of officers (and too many inmates) or whether other strategies to control this yard would be more effective. This is an issue for a correctional professional, not a mental health professional. It is clear, though, that the current situation does impede mental health care in this and similar settings. Also, as noted above, the CDCR has plans for increasing the recruitment of correctional officers, an area that I do not have the expertise to comment upon.

Direct impact of overcrowding on *Coleman* class:

I will address several specific areas in which overcrowding may impact the *Coleman* class directly.

1. Does the stress of overcrowding causes inmates who were not in the *Coleman* class upon admission to become dysfunctional, thus entering the class? Although this may seem like a "common-sense" assumption, this issue should be addressed by looking at empirical data. The data I have reviewed to date does not provide quantitative evidence of this process. In her declaration, Margaret

McAloon, Ph.D. notes that the percentage of inmates who require mental health services upon admission to the prison system (Reception Centers) is higher than the percentage in the population (which she estimated at 18% and the Special Master estimated at 19%). Her testimony is consistent with data provided by the CDCR on the percentage of mentally ill inmates in reception vs. those endorsed for placement. This is also consistent with my experiences in the reception facilities (which will be discussed in more detail below in the section on Reception Centers) that the inmates entering the prison system are likely to have a higher prevalence of acute mental illness. Furthermore, during my tour I questioned staff and interviewed inmates and did not find evidence that indeed the mental health [17] caseload has been significantly impacted by individuals who had no history of mental illness prior to incarceration. There is a category called "medical necessity" which refers to individuals who do not meet the diagnostic criteria for CCCMS or EOP but who require mental health services. This includes individuals who experience symptoms in response to the stressors in their environment (e.g., adjustment disorders). Over the course of all of my tours, I asked staff about this issue and was repeatedly told that although there are some individuals in all the caseloads who fit in this category (as would be expected in a prison environment), this is a small percentage of the caseload. Thus, although for certain individuals the stresses of overcrowding lead to need for mental health services, this is not the primary factor impacting on the size of the *Coleman* class. Rather, factors outside of the prison setting, including lack of adequate community services, contribute to the increasing number of mentally ill individuals who become incarcerated.

2. Are conditions of crowding causing decompensation among the *Coleman* class? One of strengths of the CDCR system is the classification of mentally ill inmates into categories reflecting severity of symptoms and level of function (CCCMS and EOP). The various court orders and the Program Guide provide for the more severely mentally ill inmates to be shielded from the most overcrowded settings. Thus, for example, EOP inmates are generally not housed in the "makeshift" dormitories (that is, gyms and day rooms which have been converted to housing units). These units are clear examples of overcrowding, as inmates are double and, in some cases, triple-bunked in spaces that are not designed for housing. The gym in CIM, for example, had peeling paint, was not clean, and was cramped. However, as noted there were no EOP patients housed there.

   There are CCCMS patients in these units. However, I did not find evidence that these environments resulted in significant decompensation among these inmates (based on my interviews with staff, augmented by interviews with inmates). One CCCMS inmate in the. CIM gym highlighted a paradox of these settings. He described feeling stressed in the gym and asking his psychiatrist to recommend [18] moving him to a 2-man cell, two to three months prior to my visit. He reported that the psychiatrist encouraged him to remain in the gym. I then asked him if he would ask his psychiatrist again, after the additional period in the gym, to recommend that he be moved. His response was that with the holidays arriving, he thought that he would be more at risk of becoming depressed in a cell, than being around a lot of other people. I offer this example not to minimize the problems with housing people in such inappropriate settings, but to emphasize that the focus of the inquiry is on the extent to which particular conditions can be directly related to exacerbating mental health problems.

In this regard, I queried both mental health professionals and correctional officers about whether there was any screening or mental health input about placing specific CCCMS inmates in the dormitory settings. I received variable responses, with some describing a process involving input from mental health (e.g., VSPW) and others no such process (e.g., SAC). If there are instances in which a dormitory would be unsuitable to a mentally ill inmate, therefore, it appears that this could be addressed by developing mechanisms for mental health input in those institutions which currently do not have such a process.

3. Does the high census result in inmates/patients being misclassified in terms of level of mental health need? Although acknow-

ledging the small sample size (20 individual inmates randomly chosen for interviews), it was my impression that the individuals that I met were appropriately classified. That is, the CCCMS inmates appeared psychiatrically stable, for the most part (with one exception in a Reception Center which will be discussed below), and the EOP patients were more acute, but did not appear to require a hospital bed. I understand that there are some EOP inmates who do require higher level of care who are awaiting placement, and this reflects, as noted above, the lack of sufficient higher intensity mental health beds in the system. However, for the most part, the clinical staff confirmed this impression about their ability to appropriately classify inmates in terms of mental health needs (that is, CCCMS vs. EOP).

[19] There was one circumstance, described to me by mental health staff, at CCWF where demand for beds in the EOP program led to an expedited review of patients in that unit, resulting in a number being reclassified as CCCMS. I reviewed three charts of such inmates to assess whether the decisions were clinically appropriate. In one instance, it appears that the patient had been scheduled to move out a short time later and this was moved up by one or two weeks. Another patient was deliberately moved to CCCMS because she was not cooperative with treatment and the clinical staff believed that if she continued with that pattern in general population, it would allow them to get a Keyhea order, which they felt they could not make a

case for in the more structured environment of the EOP unit.(I am not commenting on whether this is a reasonable strategy or not, but rather noting that this was not simply a decision based on needing to free up bed space.) The third chart was of an inmate who did not want to be in general population, but the clinical staff thought she could manage there - in this case I could not determine whether the decision was justified or not. These cases suggest that there should be a quality improvement process to verify that such decisions are clinically justified. If indeed patients' mental health classification is changed due to demands for mental health beds (and, aside from this situation, I did not come across this as a recurring pattern), this would reflect the lack of mental health beds and not a response to general conditions of crowding.

4. Medical records problems: In several institutions there were difficulties in clinical staff obtaining charts in a timely manner (that is, the charts were not available when needed for a clinical assessment) as well as difficulty in updating the charts (that is, delays in notes being placed in the records). Staff referred to a category of "Flimsy" charts, meaning that they sometimes had limited information available when doing an assessment. The documentation I reviewed also described institutions in which there were significant numbers of charts unified. In my opinion, this is a direct effect of overcrowding, as the number of charts in the institutions is proportional to the population (noting that charts

[20] include both medical and mental health information). This problem does impact directly on the ability to provide timely and appropriate care. In my opinion, the most reasonable solution to this problem should be focused on improving information technology, such as an electronic medical record, or at the minimum, enhanced ability to track information in an accessible database. I understand that this is an issue being pursued by CDCR and the Plata receiver, and is the most reasonable solution to this problem, in my opinion.

5. Reception Centers: In my opinion, crowding is the primary cause of the particular difficulties in providing services to the *Coleman* class at the reception centers. The percentage of inmates at the male reception centers I visited (CIM and R.J. Donovan) who were returned to prison for parole violations was extremely high (staff estimated between two-thirds to ninety percent of all admissions were parole violators). I was impressed with the ability of the mental health staff to complete their initial screenings and evaluations of these inmates in a timely manner. At CIM, for instance, staff reported that they completed these evaluations well in advance of the Program Guide requirements. However, difficulties were more apparent in terms of treatment and discharge planning. Mentally ill inmates are disproportionately represented among this group, often entering the prison system with a more acute mental health presentation, not having received adequate treatment in the community and/or

having abused substances there. Furthermore, many of these inmates receive relatively short sentences, which means that they spend their entire sentence at the reception center. Thus, even when deemed appropriate for referral to an EOP program in another prison, by the time they are processed, they are too close to discharge to warrant such a transfer. In recognition of this issue, the Reception EOP's were developed. As these are relatively new, the problems are just beginning to be worked out (as noted in the Revised Reception EOP Plan, December 3, 2007).

Furthermore, the ability to develop appropriate community plans for these individuals is limited, thus creating a vicious cycle, as they decompensate in the [21] community and quickly return ("revolving door" phenomenon). Thus, for the *Coleman* class inmates in the reception centers, it is my opinion that the difficulties in providing adequate treatment are primarily attributable to the census being too large.

One patient whom I interviewed at CIM exemplified this problem (which staff confirmed was not unique to this individual).This individual, classified as an EOP inmate (and placed in a 2-man cell rather than the day room which was being used as a dormitory), had a significant history of mental illness and was serving a short sentence (5 months) due to parole violation. It appears that he was stabilized during his brief period of incarceration but was due to be released 2 days after my visit. He reported that he would be homeless when released (confirmed by mental health staff) and appeared to have regressed during the last few days of his incarceration (he appeared depressed to me, and his psychologist confirmed that he appeared less stable on that day than he had previously).Although he claimed that he was not taking any medications, his psychologist (and the chart) confirmed that he was still being prescribed medications and was to be given a 30 day supply upon release. Nevertheless, it was clear that his community discharge plans were not adequate to maintain stability in the community. The psychologist reported that there are often difficulties working with parole in these cases, since the parole officers do not necessarily want the prison clinicians to make specific mental health referrals in the community that they do not agree to.

It is my opinion, though, that a prisoner release would not remedy this situation relative to the Reception Centers. Indeed, it would likely exacerbate the problems. As more inmates are released, even if recidivism rates remained steady (although it is reasonable to believe that an increase in releases might increase recidivism rates), this would likely result in an increase in admissions at the Reception Centers. Thus, a more reasonable solution to this issue would be to focus on better discharge planning and improved services to inmates (particularly mentally ill inmates) who are paroled into the community. Several initiatives are underway or [22] are being planned in this regard. Dr. Petersilia's affidavit discusses this issue directly, describing the Rehabilitation Strike Team's efforts, as does Scott Kernan's affidavit regarding initiatives related to parole and reentry. I am also aware of a contract with the V.A. to sign inmates up for entitlements (such as disability) prior to their release, to minimize the gap in ability to engage services in the community. Furthermore, it appears that there may be a need for better coordination between mental health clinicians in the prisons and parole in terms of recommendations for community placements (based on the report from CIM documented above). These strategies are more likely to be effective than a prisoner release.

6. Suicides in the CDCR: Based on the data reviewed, including the suicide reports from 2005 and 2006 (including the detailed case reviews of all 2005 suicides) and my interviews with staff, it is my professional opinion that the increase in suicides in the California prison system is not primarily a function of census and overcrowding. For those suicides which were considered to have been either foreseeable and/or avoidable, the problems noted were not identified as due to overcrowding issues. The data do not suggest that a higher staff/inmate ratio would significantly impact on the number of suicides. Rather, deficiencies were noted in room design (that is, failure to make the rooms more suicide-resistant, by removing grates, for example), failure to follow policy, and lack of follow-through on the institutional level to previous

recommendations. For instance, Dr. Patterson noted (p. 10) that "there continued to be significant substantive inconsistencies and inadequacies in the application of policies and procedures and in staff performance with regard to suicide prevention and management." These are issues that need to be addressed to reduce successful suicides in the prison, and are independent of the size of the prison and *Coleman* class population.

Consistent with data from other jurisdictions, the analysis of suicides identified particular problems in ad-seg settings. These problems are not primarily a function of overcrowding (as confirmed by the Special Master's Report and [23] Recommendations on Defendant's Plan to Prevent Suicides in Administrative Segregation, filed December 18, 2006). From my review of the documents and interviews with staff, I concur with these assessments that crowding is not the primary cause of the suicides in the ad-seg (or in any of the other settings). Rather, changes in policies and practices, as identified in the Special Master's report, are required. One additional issue, which I observed and noted in the documents is that some inmates are placed in ad-seg not for rules violation, but for their own safety. This policy should be re-examined, or at the least, more focused mental health services should be assigned to these individuals.

Summary and conclusions:

Based upon my review of the documentation listed and my tours of the facilities, it is my opinion that the primary issue impacting service delivery to the

Coleman class is the lack of sufficient resources at the higher intensity levels. This is not primarily attributable to the overcrowding in general, but is specific to the difficulties that have plagued the system in planning for and providing mental health services to individuals with severe mental illnesses who become incarcerated. The facilities were not designed to provide such services, and until recently, there was not adequate and comprehensive planning for the needs of this particular population. Appropriate services will require construction of units specifically designed to provide mental health treatment to inmates, as proposed in the Supplemental Bed Plan.

As noted in this report, for most of the problems noted, overcrowding is not, in my opinion, the primary reason for deficiencies in mental health care provision. I identified two areas, though, for which I thought that overcrowding was the primary factor: 1) medical records, and 2) reception centers. For the medical records problem, the most appropriate solution appears to be enhanced information technology (e.g., electronic databases, more computerized records). For the reception centers, improvements in policies and procedures for discharge planning and improved services to parolees are more likely to be effective in reducing the overcrowding at the Reception Center than [24] would a prisoner release (which may, paradoxically, increase the problems at the Reception Centers).

Ira K. Packer, Ph.D., ABPP (Forensic) Date

Addendum to Expert Report from

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Addendum to Report
re: *Coleman et al. v. Schwarzenegger et al.*
Ira K. Packer, Ph.D., ABPP (Forensic),
August 15, 2008

Introduction:

On December 10, 2007 I submitted an "Expert Report re: *Coleman et al, v. Schwarzenegger et al.*" This addendum reflects additional information I have obtained since that time From July 28, 2008 - August 1, 2008, I toured the following CDCR facilities, interviewing both staff and inmates.

- California Substance Abuse Treatment Facility (CSATF): July 28, 2008.
- CCI Tehachapi: July 29, 2008
- California Medical Facility - Vacaville (CMF): July 30, 2008
- North Kern State Prison: July 31, 2008
- Wasco State Prison: August 1, 2008

The tour of CMF was done in conjunction with a tour by plaintiffs expert, Pablo Stewart, M.D., as well as plaintiffs attorneys. The remaining tours were done in conjunction with tours by plaintiffs expert

Craig Haney, PhD., as well as plaintiffs attorneys. In addition, an attorney from CDCR as well as attorneys from intervenor parties were present during the tours. I interviewed inmates who had been selected by the plaintiffs, in addition to two interviews of inmates whom I selected at random at North Kern State Prison. A plaintiff's attorney was present during all of my interviews with inmates.

[2] In addition, I reviewed the Special Master's draft 20th monitoring report on the above facilities. I have also reviewed the following documents:

1. Court Order approving a Construction Agreement, which will include 5,000 medical beds and 5,000 mental health beds, dated 2/26/08.
2. Court Order approving Information Technology Coordination Agreement, dated 3/10/08.
3. Court Order approving Chief Executive Officer Pilot Program Coordination Agreement, dated 4/1/08.
4. California Department of Corrections and Rehabilitation's Mental Health Bed Plan submitted to the Special Master, dated July 16, 2008.
5. Transcript of deposition of Ralph Coleman, dated December 13, 2007.
6. Transcript of deposition of Doyle Scott, dated December 13, 2007.
7. Transcript of deposition of Robert G. Kennard, dated January 28, 2008.
8. Transcript of deposition of Ronald M. Shansky, M,D., dated December 10, 2007.

9. Transcript of deposition of George Sifuentes, dated December 14, 2007.
10. Transcript of deposition of Pablo Stewart, M.D., dated December 11, 2007.
11. Transcript of deposition of Jeanne S. Woodford, dated December 18, 2007.
12. Navigant Mental Health Bed Need Study, Spring, 2008.
13. Declaration of William Proctor in support of the Receiver's motion for contempt, filed August 13, 2008.
14. URS Bovis Operational Guidelines Report for California Health Care Facility, dated July 8, 2008

I reserve the right to supplement this report as additional relevant information becomes available.

Significant changes since my last visit in November, 2007:

Crisis Beds:

The only facility which I toured on both visits was CMF–Vacaville. The most significant change since my last tour was the construction of a CTC, with 50 crisis beds. The facility had only been open for a few weeks, and was not yet up to capacity (39 of the 50 beds were filled on the day of [3] my visit), as the staff had asked for a phase in of admissions to allow for smooth operation. I was informed by staff that they were progressing ahead of schedule for full deployment. The facility was very impressive, with adequate space for treatment and for staff office space. This facility accepts inmates from other institutions who require licensed Mental Health Crisis

Beds (MHCB). The added capacity for crisis beds will help ameliorate some of the backlog for this level of service. Clinical staff at CCI Tehachapi commented that they have already accessed these beds, and that this has helped them manage their inmates in crisis. In addition, this is a demonstration of how new construction, which incorporates the necessary space and is designed with treatment needs in mind, can be effective (similar to the intermediate care – ICF – freestanding facility which I observed during my first visit to Salinas Valley State Prison).

DMH Acute Psychiatric Program

Another significant advance noted in CMH-Vacaville was that the waiting list for inmates into the Acute Psychiatric Program (APP) run by DMH had been dramatically reduced. On the day of my visit, the waiting list was only 15 (I was informed that this was down from a waiting list of over 50).

Reception EOP Programs

Both North Kern and Wasco State prisons have functioning 'FOP programs for reception inmates (RC). Although this is not a change since my last visit, the RC EDP programs are relatively new (begun in 2007) and appear to be functioning well at this point in time. Both staff and inmates in the program described the program in positive terms and there were indications that the inmates were receiving the required elements of the program without significant difficulty. Officers were specifically assigned to transport EOP inmates to programming, and from all reports this is working well.

I note that at North Kern, two inmates who were classified as CCCMS complained to me during my interviews with the that they wanted to be reclassified as FOP, as they observed the enhanced services those inmates received. (Parenthetically, it did not appear to me that these two inmates had been inappropriately classified as CCCMS.) This sentiment reflects a positive valuation by inmates, as it is considered desirable by them to get admitted to the program.

[4] I did have an opportunity to interview one inmate at North Kern, in Reception Status (that is, awaiting placement from the Reception Center to a mainline prison), who was classified as EOP and who had been placed in Administrative Segregation (Ad Seg) due to rules violations. He acknowledged that services he received while in the EOP general population were "alright" but complained that he was not receiving full services in Ad Seg. He had been endorsed to leave the Reception Center to go to an EOP program on a Special Needs Yard (as he was a gang drop-out, thus requiring a more protected environment), but this transfer was delayed. This inmate is an example of a group of inmates who are difficult to serve because of the difficulties inherent in dealing with inmates with complicated mental health and security needs. He was not only classified as EOP, but also Special Needs, as well as having security issues related to his rules infractions. I was informed that a Special Needs Yard for EOP inmates was about to come on line at Kern Valley.

Other observations:

Need for more EOP beds and more ICF (intermediate care provided by DMH)

Consistent with my initial report, during this visit I obtained similar information regarding the long waiting lists for FOP programs, as well as a very significant waiting list for Intermediate Care beds (I was informed that the waiting list for the ICF was 167, and that some inmates had been removed from the list as they were so low down as to be unlikely to obtain a bed in any reasonable time period). Inmates requiring these services are the most severely impaired by mental illness; as I indicated in my previous report, a general prisoner release is unlikely to significantly impact this problem. Additional resources for this population are needed and will continue to be needed even if the overall census in CDCR is reduced. In this context, I have reviewed the CDCR proposal for consolidated care facilities, which includes significant enhancement of EOP, ICF, and acute care beds (for a total of 5,000 mental health beds in these facilities). This plan appears reasonable in terms of meeting the needs for this population. It is [5] also my opinion that consolidating these beds in specific facilities is an excellent idea, as it will allow for ease of recruitment of staff as well as efficiency of service delivery.

Crisis beds:

I observed variability across facilities in terms of adequate number and management of crisis beds, CSATF appeared to be have few difficulties, reporting that they have rarely have "maxed out" their beds, and take inmates from other facilities. Clinicians at CCI Tehachapi reported that they had decreased their transfers to crisis beds over the past 6 months. One of their strategies was to have clinicians see inmates in OHU (Holding Unit cells) on a daily basis and discharge back to population those who did not really require a crisis bed. (There is a low threshold, appropriately, for placement in a holding cell; inmates who make suicidal statements are placed in such cells and observed closely. Many of these inmates are not genuinely suicidal and do not require hospital level of care as is provided in crisis beds; a period of observation to triage those genuinely requiring those beds is reasonable.)

North Kern had developed a capacity to use cells on another unit as observation cells, prior to those inmates being transferred to a crisis bed (MHCB), and this system appeared to be working reasonably well. On the day of my visit, they had no inmates in their holding cells. Although they had not received authorization from CDCR to staff these cells at a level required for an OHU, they were attempting to provide services to inmates in those cells comparable to an OHU. For instance, a psychologist from the MHCB visited the holding cell unit daily in order to provide continuity of care. Clinical staff informed me that 70% of inmates in the holding cells were discharged back to population within 3 days and the remaining 30% were admitted to a crisis bed.

Wasco State Prison appeared to have more difficulty accommodating the need for crisis beds. They too used another unit for holding cells, although on the day of my visit those cells were all full and these cells were on a unit which also had overflow beds on the floor. Of more concern in this facility, was a mentally ill inmate who had been admitted in Reception the night before and had to spend the night in a cell in the reception area (which had no bed, toilet, or sink). This [6] inmate was watched continuously, but had spent almost 24 hours in the cell in the reception area, which was clearly not an appropriate place. Staff indicated that this was a rare occurrence, and stated that this should not have occurred (that is, mental health leadership should have been notified to find an appropriate bed). Nevertheless, this appears to be a situation which resulted directly from a lack of adequate capacity for crisis beds in that facility.

Reception

As with my first visit, it appears that the reception centers are overwhelmed by the large number of admissions of individuals who are experiencing mental illness. Although clinical staff manage to do a good job of mental health triage, it is still difficult to provide adequate services to this particular population. North Kern, for example, had creatively converted a cell in the Reception area for a psychiatrist and psychologist to use, and they were thus able to interview inmates referred by the nurse in a timely manner and triage these cases. For the Coleman class in Reception, the RC EOP program is very helpful, but more crisis beds are needed and there are still significant delays getting these individuals into other programs (such as EOP programs in mainline prisons, or intermediate care programs). As noted above, the problems are exacerbated when inmates have multiple problems or issues (such as requiring a Special Needs Yard or the highest levels of security).

Treatment and office space

As with my first visit, there were clearly identified issues of finding adequate space in a number of the facilities for office space for clinicians. In CCI Tehachapi, for instance, a psychologist was using a converted broom closet, which she shared with another clinician. In Wasco, there was very limited space available to both clinical and clerical staff. North Kern had been able to convert a former visiting area into office space for their clinicians. CSATF did have a centralized Mental Health office with space for clinicians.

There were also problems in a number of the facilities finding adequate treatment space. Administrative and clinical staff were creative about using chapels and other spaces, although there were both conflicting demands for these spaces as well as heat issues in some places (that is, some rooms could not be used during the hottest days).

[7] Overflow beds

Across my tour, I observed gyms that had been converted to housing space (double or triple bunked). EOP patients were to be excluded from these spaces and I was repeatedly informed that indeed EOP patients were either not placed there, or if they were, were quickly identified and moved out CCCMS patients were found in these units. In addition, some of the units with cells had overflow beds on the floors (e.g., Wasco). Again, FOP inmates were not placed there, but CCCMS inmates were. On one of the units at Wasco, the sergeant informed me that the overflow beds were actually considered more desirable by the inmates than the cells, as they had more access to the TV and increased mobility.

I interviewed a number of CCCMS inmates who were housed in gyms. Their reactions to that space were mixed; some preferred it to being in a cell (as they were more restricted in the latter), while others found it too noisy and distracting. Correctional officers informed me that inmates were selected for these gyms based on lower security status and proximity to discharge. They also characterized these units as not having "a lot of drama," by which they meant not a lot of behavioral management issues. Clinical staff also reported that in their experience, they did not find that CCCMS inmates in these units decompensated (that is, experienced serious exacerbations of their mental health symptoms, thus requiring a higher level of care, or becoming suicidal) due to the environment. Thus, despite other issues which make use of such space undesirable, I did not find that this was having a significant impact on the CCCMS inmates in terms of exacerbation of psychopathology. I was also informed that if clinical staff determine that a particular inmate is not able to cope with these units, that this information is shared with administration and the inmate will be moved.

I interviewed 3 randomly chosen CCCMS inmates in a reception dorm at North Kern. These inmates all complained about lack of therapeutic activities for them in the facility. However, they all seemed to be psychiatrically stable, and did not appear to meet criteria for EOP (based on a very limited, cursory interview). These types of inmates are more likely to be appropriate for [8] additional therapeutic services after they have been moved out of the reception centers to mainline prisons.

Discharge planning

I found a mixed picture regarding discharge planning with parole for inmates with mental health issues. CCI Tehachapi has a designated pre-parole coordinator, and clinical staff reported that coordination was going well with parole, in terms of obtaining needed services for parolees. I also spoke with a social worker at North Kern who was assigned to work on pre-parole issues with EOP inmates. She indicated that the program had started about a year ago and appeared to be working well with most parole officers (although they did not have any outcome data, in terms of recidivism). By contrast, a psych tech at Wasco reported her experience of inconsistencies in working with the Transitional Case Management Program. I note that when I visited CIM last year, I was informed of significant problems coordinating with parole. I do not have data on whether the situation has improved in that facility. Based on the information from my current visit, it does appear that there are some successful models that are being implemented, but I cannot speak to the issue of how this is working system-wide.

Adequate numbers of clinical staff

Consistent with my previous report, there were differences across facilities in terms of ability to attract and retain clinical staff These issues tended to be a function of geography (i.e., more difficult to find permanent staff in more remote areas, away from large population centers). In some of these facilities (e.g., CCI Tehachapi), there was significant reliance on contractor staff However, it appears that most contractor staff were not transient, but stayed for a significant period of time. Indeed, the Chief Psychiatrist at that facility is a contractor himself, has been there for a while, and explained that there is often no difference in quality or commitment between state employees and contract staff, but rather some psychiatrists prefer the contractor status because of financial considerations. This is likely to be an ongoing issue, regardless of the census in CDCR. However, the plan for Consolidated Care Centers is likely to be helpful in attracting and retaining permanent staff.

[9] Summary

As noted, many of the issues identified in my previous report were confirmed during this current visit. However, there was also some significant evidence of improvement in some areas, particularly the new MHCB unit at CMF, progress at the RC EOP programs at North Kern and Wasco, and reduction in the waiting list for the Acute Psychiatric Program (APP) at CMF. Also, significantly, there is now a proposal, with a timetable, for development of Consolidated Care Facilities, with 5,000 mental health beds included. As I indicated in my previous report, it is my opinion that the major obstacle facing CDCR in providing adequate mental health care to inmates is the lack of adequate beds and resources to serve inmates with intensive mental health needs. The new proposed model, which includes these Consolidated Health Care facilities, should significantly address the problem by providing more beds, better facilities, more treatment space (including freeing up space in existing facilities), and increasing the likelihood that qualifred staff can be recruited and retained. These Health Care facilities are being constructed with a therapeutic goal in mind and thus are likely to be more effective than previous attempts at retrofitting existing space designed for correctional purposes only. As indicated in the Operational Guidelines for these facilities, prepared by URS Bovis (p. 4), the new facilities "will be unlike any correctional facility currently found within the existing California Department of Corrections and Rehabilitation (CDCR). . . . There will be an emphasis on achieving a therapeutic environment that is conducive to appropriate levels of treatment and restorative care and programs for both medical and mental health patients."

/s/ Ira K. Packer, Ph.D.
Ira K. Packer, Ph.D., ABPP (Forensic)

August 15, 2008
Date

Electronically signed. Original mailed 8/15/2008

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C01-1351-T.E.H.

MARCIANO PLATA, *et al.*,
Plaintiffs

v.

ARNOLD SCHWARZENEGGER, et al.,
Defendants,

RECEIVER'S REPORT RE OVERCROWDING

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[1] I.

INTRODUCTION

In the Order filed February 15, 2007 the Court directed "the Receiver to report to the Court within 90 days of the date of this Order, his best assessment of the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue." *Order* at 4:3 - 13. The Order also called for the Receiver to provide the Court with information concerning the "types of obstacles" that overcrowding presented to the Receivership. *Id.*

This report responds to the Order. It is organized as follows:

Section II. summarizes the findings which led to the Receivership. It also references the Receiver's Plan of Action concerning those remedial programs necessary to bring California's prisons up to constitutional standards.

Section III explains the special characteristics of prison overcrowding in California. As explained below, the specifics of prison crowding are far worse than previously explained by State officials. Furthermore, the characteristics of overcrowding within California's massive prison system have especially adverse consequences concerning the delivery of medical, mental health, and dental care. The impact of overcrowding presents complicated problems, challenges which further complicate the already difficult remedial challenge faced by the Receivership. Thus, very specific information relative to the real-life impact of overcrowding is necessary to provide relevant background data concerning the types and the scope of crowding related obstacles that interfere with the remedial programs developed by the Receiver.

Section IV summarizes the manner by which overcrowding interferes with the Receiver's remedial projects, discussing both "substantive" and "process" related interference. Section V analyzes the real life impact of the recent 2007 California Legislation.

Section VI provides a conclusion concerning the Court's directives of February 15, 2007.

[2] II.

CONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

The California Department of Corrections and Rehabilitation ("CDCR") has failed to deliver constitutionally adequate medical care to the more than 170,000 prisoner/patients presently incarcerated in the State of California. There are three relevant frameworks of analysis within which it is possible to summarize the "constitutional violations at issue" referenced in the Court's February 15, 2007 Order.

B. Court's Findings of Fact and Conclusions of Law of October 3, 2005.

The Court's Findings of Fact and Conclusions of Law re Appointment of Receiver filed October 3, 2005 set forth facts which demonstrated that California' prison medical delivery system was broken beyond repair, holding that future injury and death was virtually guaranteed in the absence of drastic action. Those findings will not be repeated here; however, the Receiver believes it important to point out the following. As found by the Court, California's prison medical care crisis has persisted for decades. And while the State had ample opportunity to improve medical conditions, it failed to do so. The failure was caused, to a significant degree, by institutional paralysis and a lack of will. The State's response to decades of overcrowding is similar; despite various task forces, numerous studies and reports, and Special Sessions, California has not instituted any effective response to the worsening overcrowding crisis.

C. The Receiver's Bi-Monthly Reports.

The Receiver has submitted four Bi-Monthly Reports. Each provides up-to-date information concerning the deplorable state of California's prison medical care delivery. To summarize, the Receiver concludes that the degree of operational chaos within the CDCR, the institutional paralysis in many State agencies, and trained incompetence are even worse than indicated by the Court's findings.

[3] D. Defendants' Inability to Provide Basic Medical Care Services Required by Plata Stipulations.

1. *Introduction.*

The final relevant measure of the "unconstitutional violation at issue" is the twenty-eight basic prisoner/patients services called for by the June 13, 2002 Stipulation for Injunctive Relief. These are the services which the State, for more than five years, had failed to provide.

2. *Provisions for Prisoner/Patient Services.*

1. Health screening: A process for screening all patients for communicable disease, such as tuberculosis and sexually transmitted disease, and chronic disease, such as diabetes, renal disease, seizure disorders, cardiovascular disease, and pulmonary

disease; screening for cancer; review of vital signs, blood pressure, pulse, and weight; review of current medications; and nurse review and referral for patients with urgent or acute conditions; history and physical examination for all patients within 14 days of arrival at Reception Center; and routine laboratory tests, such as serum pregnancy, cholesterol screening, and optional HIV testing. (Stipulated Injunction ¶ 4)

2. Health transfer: Process to ensure continuity of care when patients transfer to another institution, transfer between levels of care, or are paroled, including continuity of medications, specialty referrals, and other treatment. (Stipulated Injunction ¶¶ 4, 6)

3. Access to Primary Care (Sick Call): System that allows patients to self-refer for medical treatment, including nurse review to identify the need for immediate referral to urgent or emergency treatment, an urgent walk-in procedure, and follow-up services; policies require face-to-face nurse triage for patients with symptoms within 24 hours, and an appointment with a primary care provider within 5 days for patients classified as urgent and within 14 days for patients classified as routine. (Stipulated Injunction ¶ 4)

4. Priority Ducat System: System for ensuring that custody staff treat health care appointments as high-priority. (Stipulated Injunction ¶¶ 4, 6)

5. Patient Health Care Education: Program to provide patients with instruction in wellness, lifestyle changes, disease prevention, newly diagnosed illness or disease, treatment [4] plans or proce-

dures, pre- and post-operative care, chronic care morbidity reduction. (Stipulated Injunction ¶ 4)

6. Preventive Services: Services to prevent disease and mitigate morbidity and mortality due to existing disease provided to select patient populations based upon risk factors, such as age and chronic conditions, that include cancer screening, immunizations, and health education (education regarding diet, exercise, smoking cessation, etc.). (Stipulated Injunction ¶ 4)

7. Outpatient Specialty Services: Program for providing specialty services, including procedures for urgent and routine referrals and required follow-up; policies require that high-priority consultations or procedures occur within 14 calendar days and routine consultations or referrals within 90 calendar days, with follow-up by a primary care provider within 14 calendars days after the consultation or procedure. (Stipulated Injunction ¶ 4)

8. Physical Therapy: Program to ensure timely access to physical therapy services, including specifications for the follow-up by primary care providers and provisions for transferring to an institution with these services if the home institution does not provide them. (Stipulated Injunction ¶ 4)

9. Diagnostic Services: Program for the appropriate processing of laboratory tests and other diagnostic testing, including procedures for prioritizing the urgency of laboratory orders (STAT, critical, urgent, routine) and required timeframes for review and follow-up of results (routine laboratory tests processed within 14 days of order, x-ray examinations completed within 30 days of order, primary care provider review of lab results within two business

days of receipt, notification of patient of results within 14 days of receipt). (Stipulated Injunction ¶ 4)

10. Medication Management: Services to dispense, administer, and distribute pharmacotherapeutic treatments, including provisions for medication error reporting, medication follow-up counseling, medication renewals and refills, medication for parole, and continuity of medication upon transfer; policies require that prescriptions for formulary medications be filled by the following day and that "stat" medications be issued within 1 hour. (Stipulated Injunction ¶ 4)

[5] 11. Urgent/Emergent Response: Program for the provision of urgent care services and 24-hour emergency medical treatment that includes basic life support, emergency response, and physician on-call services; policies require follow-up within five days for patients whose urgent encounter was due to chronic disease. (Stipulated Injunction ¶¶ 4, 6)

12. Medical Emergency Response Documentation and Review: Process for the review of deaths, suicide attempts, and calls for emergency assistance to determine compliance with existing policies and procedures, adequacy of response time, and appropriateness of custody and medical response and patient treatment, with follow-up actions to address identified deficiencies. (Stipulated Injunction ¶ 4)

13. Outpatient Housing Unit and Licensed Care: Specialized treatment services for varying levels of acuity, including outpatient services requiring specialized housing (Outpatient Housing Unit care), licensed skilled nursing facility care (Correctional Treatment Center care), General Acute Care Hospital care, and palliative care; policies require physician

evaluation within 24 hours of admission to a Correctional Treatment Center and an evaluation by a primary care provider within 5 days for all patients returning from an inpatient acute care facility. (Stipulated Injunction ¶ 4)

14. Outpatient Therapeutic Diets: Program for the provision of nourishments and supplements for patients who are pregnant, diabetic, immunocompromised, malnourished, or have oropharyngeal conditions causing difficulty eating regular diets and special diets for patients with renal failure or hepatic failure, or who require a Heart Healthy diet, gluten-free diet, or diet to preclude food allergies. (Stipulated Injunction ¶¶4, 6)

15. Medical Report of Injury or Unusual Occurrence: Process for documentation of patients' on-the-job injuries, physical contact with a staff member during an incident, and any self-reported injury due to self-injury or altercation, Administrative Segregation Unit placement, use of force, or other medical emergency situation. (Stipulated Injunction ¶ 4)

16. OC Contraindications: Process for the evaluation and treatment of patients prior to or after the use OC. (Stipulated Injunction ¶ 4)

[6] 17. Medical Evaluation of Patients Involved in Assaults: Process for the evaluation of patients who have been involved in the use of force, including review of the patient's mental health record. (Stipulated Injunction ¶¶ 4, 6)

18. Hygiene Intervention: Process for the identification, evaluation, and referral of patients who demonstrate poor hygiene or whose hygiene compromises the sanitation/hygiene of their personal and immediate housing area. (Stipulated Injunction ¶¶ 4)

19. Inmate Hunger Strike: Process for the identification, evaluation, and treatment of inmates on hunger strike, including required coordination and reporting between custody and health care staff. (Stipulated Injunction ¶ 4)

20. Comprehensive Accommodation Chrono: Process for the authorization and review of special equipment, housing accommodations, or other accommodations that are medically necessary or are required under the Americans with Disabilities Act. (Stipulated Injunction ¶ 4)

21. Pregnant Patient Care and the Birth of Children: Prenatal care and post-delivery services, including required screenings, frequency of prenatal treatment visits, vitamin and nutritional requirements, referrals for child placement services, and postpartum follow-up; policies require that patients be seen by a obstetrics provider within 7 calendar days of determination of pregnancy that each patient be provided six-weeks post-delivery for follow-up. (Stipulated Injunction ¶ 4)

22. Nursing Services and Protocols: Clinical protocols for nurses in the appropriate evaluation and treatment of patients presenting with specific systemic conditions or complaints. (Stipulated Injunction ¶¶ 4, 6)

23. Health Record Services: Provisions for the management, content, and archiving of patient health records, including policies for disclosure of information. (Stipulated Injunction ¶ 4)

24. Chronic Care Program: Diagnosis and management of chronic disease (diseases lasting longer than 6 months), including identification and treatment of high-risk patients; policies require an

initial intake evaluation within 30 days for patients referred to the Chronic [7] Care Program, and ongoing evaluations every 90 days. (Stipulated Injunction ¶¶ 4, 6)

25. Pharmacy Services: Provisions governing pharmacy operations, including pharmacy licensing, emergency drug supplies, drug storage, consultation with a pharmacist, prescription requirements, and the ordering, stocking, and receiving of medications. (Stipulated Injunction ¶ 4)

26. Public Health and Infection Control: Program for infection control, communicable disease reporting, and bloodborne pathogen control. (Stipulated Injunction ¶ 4)

27. Telemedicine Services: Program for the provision of specialty services through videoconferencing. (Stipulated Injunction ¶ 4)

28. Utilization Management: System to facilitate appropriate use of resources for patients requiring higher levels of care and select specialty services and medications, including reviews to determine placement at appropriate level of care and appropriate utilization of specialty care and pharmacy resources. (Stipulated Injunction ¶ 4)

3. *The Receiver's Plan of Action.*

On May 10, 2007 the Receiver filed his initial Plan of Action to remedy the unconstitutional medical care system in California's prisons. (Exhibit 1.)[1] As set forth in the Plan, the CDCR requires an entirely new infrastructure of medical delivery before necessary programs of clinical remediation can be effectively implemented in a sustainable manner. Therefore, when considering "the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue," the Receiver necessarily referred not only to the stipulated injunctions re medical delivery (standards agreed to by the attorneys in this case), but also to the substance of the Plan of Action that will be necessary to successfully remedy the unconstitutional medical conditions in California's prisons.

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[1] All exhibits referenced in this report are found in the Appendix of Exhibits Supporting the Receiver's Report Re Overcrowding filed concurrently with this Report.

[8] E. Unconstitutional Medical Conditions Are Only One Part of an Unconstitutional Prison Health Care Delivery System.

Context is critical. The State of California has allowed its massive prison system to operate with unconstitutional levels of medical care. At the same time, however, the State is under Federal Court mandated remedial plans concerning the delivery of Mental Health, Dental, and Americans With Disability Act services. Under the best of circumstances, correcting medical problems present a significant challenge; however when the medical remedial plan must also consider the legitimate remedial objectives of the *Coleman*, *Perez*, and *Armstrong* class actions, in addition to uncontrolled overcrowding, the scope, duration, and cost of Federal Court intervention may increase dramatically, as explained below.

III.

THE SCOPE AND CHARACTERISTICS OF PRISON OVERCROWDING IN CALIFORNIA

A. Introduction.

From the perspective of a Receivership tasked with creating a medical delivery system that meets constitutional minima, the size, scope, pervasiveness and specifics of overcrowding in California's prisons have special negative consequences, as explained below.

B. The Pervasiveness of Prison Overcrowding in California.

1. *Introduction.*

Prison overcrowding is not a new phenomenon in California. To the contrary, overcrowding has been a way of life in the CDCR for twenty years. For example, as demonstrated below, overcrowding is ingrained in the CDCR style of constructing and managing prisons. Crowding related policies that do not provide adequate clinical and program space are now an accepted practice of CDCR prison planning, as is California's practice of offering inadequate salaries and failing to provide adequate hiring programs which have created crisis levels of shortages of clinical personnel and correctional officers.

[9] 2. *The Long Term Continuation of California Prison Overcrowding.*

Despite spending billions of dollars on construction, the level of overcrowding in California's prison system has not decreased; indeed, despite waves of prison expansion overcrowding has now reached crisis levels.

Exhibit 2 charts prison by prison and system-wide overcrowding from June 30, 1997 to May 4, 2007.[2] To summarize, in 1997 there were a total of 32 prisons within the CDCR with an average overcrowding rate of 196.0 percent for Males and 175.3 percent for Females. In 2002 there were 33 institutions (with the additional of Substance Abuse Treatment Facility ["SATF"] and an average overcrowding rating of 191.3 percent for Males and 155.9 percent for Females. In 2007 the number of institutions remained at 33.[3] The Statewide overcrowding average for Male inmates increased to 196.4 percent and the Female overcrowding rating increased to 175.8 percent. In 1997 there were 11 institutions at or above 200 percent of overcrowding. By 2002 that number had increased to 12 institutions. By 2007, 19 institutions were at or above 200 percent of overcrowding. To summarize, despite massive waves of construction, prison overcrowding has grown worse in California.

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[2] The chart was created based on the data obtained from the CDCR's Data Analysis Unit (from the "Monthly Report" for the dates specified).

3. *The Consequences of Decades of Overcrowding.*

No one disputes the consequences of decades of prison overcrowding; indeed, both formal studies and official proclamations affirm the crisis nature of today's overcrowding. For example:

a. Corrections Independent Review Panel.

Three years ago, June 30, 2004, an independent panel of experts, chaired by former Governor George Deukmejian issued a report entitled "Reforming Corrections." In a section titled "Inmate/Parole Population Management" the panel found California's prisons "filled to the [10] breaking point," exceeding both "safe and reasonable capacity" and "far exceeding operable capacity." (Exhibit 3.)[4] The panel also found that numbers alone understated the impact of overcrowding, that staffing reductions have accompanied overcrowding, and that overcrowding and inadequate staffing impedes programming. The panel made a number of crowding related recommendations, none of which have been implemented.

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[3] Kern Valley State Prison ("KVSP") was activated and Northern California Women's Facility ("NCWF") was deactivated.

b. Little Hoover Commission Report.

On January 25, 2007 California's Little Hoover Commission issued a report entitled "Solving California's Corrections Crisis - Time is Running Out" finding that California's prisons are swelled past capacity, that as a result of crowding there was little room or budget for rehabilitation, that California had a recidivism rate of 70 percent (near the highest in the United States), and that thousands of correctional officer shortages have created huge overtime bills and mounting stress for those officers on duty. (Exhibit 4.)

c. Governor Schwarzenegger's Declaration of Emergency.

On October 4, 2006 Governor Arnold Schwarzenegger proclaimed a State of Emergency because of prison overcrowding, declaring that "the current severe overcrowding in 29 CDCR prisons has caused a substantial risk to the health and safety of . . . the inmates housed in them . . . The declaration further stated that overcrowding puts prisoner/patients in "increased, substantial risk for transmission of infectious illnesses."

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[4] The entire "Reforming Corrections" report is found at cpr.ca.gov/report/indrpt/corr.

4. *A Progressive Lowering of Standards: CDCR Facilities Master Plans.*

A telling example of the CDCR's institutionalized acceptance of overcrowding and the lowering of correctional standards to accommodate overcrowding is found in CDCR "Facility Master Plan" documents. Exhibits 5, 6, and 7 contain relevant sections from the CDCR's Facility Master Plan for 1993-1998, 1995-2000, and 1998-2003. Reviewed in sequence, they provide insight into a correctional mindset that allows *overcrowding* rather than *sound correctional management* to drive crucial construction and prisoner management policy. Note [11] the following:

1. No Master Plan addresses overcrowding driven problems with the delivery of medical services. All the plans focus on corrections, as if medical, mental health, and dental care have no place in prison design, prison construction, or prison management.

2. As the CDCR failed to "build its way out" of the overcrowding crisis, crowding restrictions were steadily lowered, until by the issuance of the 1998-2003 Plan there were essentially no restrictions. For example, the 1993-1998 Master Plan (Exhibit 5) limited celled crowding to 130 of design percent and dormitory crowding to 120 percent of design capacity. By the 1995-2000 Master Plan (Exhibit 6), however, a 170 percent crowding standard was utilized for the *highest security prisoners, Level IV*. The 1998-2003 Master Plan (Exhibit 7) allowed for a 190 percent crowding rate at almost all prisons (and for the housing of prisoners in gyms). During these same years various CDCR housing definitions were repeatedly modified, and new terms were instituted such as "crisis" and "nontradtional" (the CDCR's designation

for prisoners housed in classrooms, hallways, etc.). Prison staff refer to such beds as "ugly" beds.

C. California Prison Overcrowding Is Accompanied by Severe Staffing Shortages.

1. *Clinical Staffing Shortages.*

The Receiver has previously reported to the Court about the serious clinical vacancy rates throughout the CDCR's medical delivery system. Likewise, reports have issued concerning staffing shortages in the *Coleman* and *Perez* class actions. When considering the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue, the Receiver must take into consideration the fact that overcrowding is accompanied by serious staffing shortfalls for both clinical providers and correctional officers.

For example, Exhibit 8 provides a snap shot comparison of clinical staffing shortages between January 31, 2002 and January 31, 2007.[5] Concerning, every clinical category except for [12] registered nurses, vacancies are worse today than five years ago.[6]

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[5] One difficulty encountered by the Receiver when preparing this report is that limited and at times inaccurate staffing data is maintained by the CDCR. The figures in Exhibit 8 were obtained from the State Controller's Office; thus, there may be a time lag in the reporting of actual staffing shortfalls, as well as hires. Nevertheless, these numbers represent accurate "ball park" estimates of the scope of staffing shortages between 2002 and 2007. These numbers do not, however, consider future staffing enhancements and roll-outs. According to CDCR staff, hundreds of additional dental, medical, and mental health clinicians will be needed to comply with remedial plan standards.

The true scope of clinical staff shortfalls is actually *far worse* than the numbers set forth in Exhibit 8 because there are additional staffing needs projected in each of the health care class actions as well as upcoming time-phased "roll-outs," none of which are yet listed on the chart.

2. *Custody Staffing Shortages.*

Correctional officer vacancies on April 30, 2002 were 1,179. As of January 31, 2007 "budgeted" correctional officer vacancies had risen to 1,915.[7] However, the actual total of officer vacancies is several hundred higher than the "budgeted" vacancies due to the practice of assigning "unbudgeted" positions for posts such as medical guarding at community hospitals, and monitoring and providing services for prisoners confined to "nontraditional" beds. CDCR officials estimate the actual officer shortage to be somewhere between 2,400 and 2,700.

Based on response to numerous inquiries by the Office of the Receiver, there appear to be no innovative or unique CDCR program that has been developed to address the correctional officer shortage. To the contrary, the existing system of recruitment and hiring is experiencing bottlenecks in its recruitment process that may have an adverse impact on the number of cadets admitted to future academy classes.

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[6] Improved rates of hiring and retaining registered nurses are the result of the Receiver's salary increase and the Receivership's streamlined clinical hiring process.

[7] These figures were provided by the CDCR's Human Resources Division based on State Controllers Office data.

For example, according to CDCR personnel, as of Friday, May 11, 2007 there were somewhere between four to seven thousand "unassigned" background verifications awaiting processing (background checks are required for correctional officer applicants who successfully complete the CDCR's initial testing programs). The exact backlog is not known in that the background unit is behind in entering data into its computer tracking [13] system.

3. *Managerial and Executive Staffing Shortages.*

In addition to the severe staffing shortfalls within the ranks of clinicians and correctional officers, the CDCR has also experienced very significant turnover among its executive and managerial ranks, ranging from Secretaries to Wardens. Likewise, given the unconstitutional conditions in health services, turnover among prison Chief Medical Officers and Chief Physicians and Surgeons remains excessive.

D. The Short Average Length of Sentences Among California Prisoners.

According to CDCR statistical records, the average sentence for a California prisoner is 46.7 months, and the average time served is 24.1 months. (Exhibit 9.) Given the fact that California confines thousands of prisoners facing Life or Life Without the Possibility of Parole sentences, the CDCR average time served is indicative of two distinct classes of California prisoners: (1) longer term prisoners, a significant portion of whom (but not all) are confined to Level III and Level IV prisons; and (2) a group of short term prisoners (of whom a significant percentage are parole violators) who come into and go out of the CDCR with such frequency that the average length of CDCR sentences is pushed down to two years.

Each class of prisoner has different and distinct medical needs. Therefore, when implementing the Plan of Action, the Receiver must consider this characteristic of California prison crowding. Lifers, for example, will eventually age and require special housing as infirm patients. On the other hand, the constant churning of parolees into and out of the CDCR (and between CDCR institutions) requires special clinical and correctional support staff at reception centers and in the "receiving and release" units at each state prison.

E. The Impact and Severity of California Prison Overcrowding Varies By Institution.

1. *Introduction.*

The California prison system is unique not only in terms of its overall size and prisoner population, but also because of a wide variety of different types of prisons, the remote location of most prisons, and the different impacts of overcrowding at each specific institution. As a [14] result, overcrowding related negative impacts on the Plan of Action become both complicated and interrelated. There is no single fixed strategy that can be employed by the Receiver to bring medical care delivery in California's prisons up to constitutional standards. Invariably, the overcrowding problems at each specific prison are unique, and specialized remedial programs must be developed for each.

2. *Factors Which Determine the Impact of Overcrowding In California's Prisons.*

1. Degree of Overcrowding: As shown in Exhibit 2, not all CDCR prisons suffer from the same degree of

overcrowding. The .challenge of providing constitutional medical care at a prison with more than two hundred percent overcrowded will be different from the challenge at a prison that is less crowded.

2. Institution Size: California opted to construct mega-prisons in the 1980s and 1990s, a strategy rejected by other jurisdictions. In addition, California has a policy of adding new prisons to sites with older prisons, creating a number of prison complexes (e.g. the California Institute for Men ["CIM"] and the California Correctional Institution at Techachapi ["CCI"]). Ultra-large prisons and prison complexes which are severely overcrowded, as they are today, create special medical delivery challenges, as well as recruitment difficulties.

3. Remote Location: Many of mega-prisons constructed in the 1980s and 1990s have been sited in remote locations, far from the urban centers where it may be possible to recruit adequate numbers of competent clinicians. With the remote prisons so severely overcrowded, recruitment problems have intensified, not only for clinical personnel but also for correctional officers.

4. Institutional Design: Because of overcrowding, many California prisons which should have been decommissioned decades earlier remain not only fully operational, but operate at 200 percent of their design capacity. Thus in terms of real life remedial fixes, it is a far different problem addressing the impacts of overcrowding on the aged, poorly maintained and diverse housing units at San Quentin or Old Folsom, compared to the impacts of crowding presented by [15] a prisoner population of more than 260 percent of design capacity as at the more modern

but sprawling and remotely-located prison located at Avenal.

5. Institution Mission: Many CDCR prisons have been charged with special "missions." Because there has been no adequate long-term planning in CDCR, prison specific missions have been assigned in a manner that inhibits the establishment of a safe and effective medical remedial plan. In most cases the designation of CDCR prison "missions" are comprehendible only in a historical context. The diversity, lack of organization among missions, ad hoc and incompetent changes in mission combined with severe crowding will complicate the timely and cost effective implementation of the Plan of Action, especially when the Plan calls for assigning the appropriate patient to the appropriate medical delivery facility.

For example, Avenal State Prison has been designated for *Armstrong* class members and for housing older, low security prisoners - despite its remote location and the resulting difficulties hiring adequate numbers of clinicians. Salinas Valley State Prison contains a long term "Intermediate" mental health facility for high security inmates, despite being hundreds of miles from outpatient mental health units at Pelican Bay State Prison ("PBSP") and California State Prison-Sacramento (which feed patients into and accept patients from the Intermediate unit). Prisoners with medical conditions that may make them especially vulnerable to Valley Fever, for example, patients with serious kidney problems, are housed in prisons in the Central Valley, the primary locus of Valley Fever spores, because those facilities have been designated for the delivery of dialysis treatment. Correcting these types of anomalies will be difficult, requiring an entirely new program of cohorting patients, which will in turn require modifications to the manner by which CDCR classifies inmates and assigns them to specific prisons. This challenge is rendered far more difficult, however, because of the extent of the CDCR's overcrowding.

F. The Velocity of Prisoner Movement Within the CDCR.

1. *Introduction.*

Overcrowding creates increased prisoner movement as correctional officials struggle to [16] manage crowding by transferring prisoners from institution to institution in a constant search for "open" beds. This form of crowding driven movement adversely impacts on health care delivery in at least six important ways. First, adequate health care in the correctional environment requires some form of "intake" or "reception" screening whenever a prisoner arrives at an institution. The health care screening (medical, mental health, and dental) that takes place at a CDCR Reception Center is necessarily wider in scope and more complete than the intake screenings which take place as a result of inter-prison transfers; nevertheless, both processes call for specific clinical reviews, reports, and the coordination of necessary follow-up care. Thus, an increase in prisoner movement equals an increased workload concerning screening. Second, all "out" transfers from a CDCR prison require action by health care staff, including, in some cases, an evaluation of whether the prisoner is fit for transfer. Third, the appropriate medical records must accompany the transferring prisoner. However, given the existing transportation process, the speed by which transfers need to be effectuated, and the absence of any form of electronic record, this means that a paper record must be assembled, updated, transported to the intake and release area and physically placed inside the transportation vehicle with the transferring prisoner for delivery to the reception nurse at the receiving institution in time for the intake screening. Not surprisingly, many prisoners are transferred without their records. Fourth, some percentage of inmates who are transferred must be provided with medication during the transfer process, and plans must be initiated for the timely renewal of medications at the receiving institution, placing an additional work load on physicians, pharmacy personnel, nurses and correctional officers. Fifth, some percentage of transferring inmates must be afforded special transportation (and in some cases must be accompanied by clinical personnel) during the transfer, a staff intensive procedure for both clinical and correctional personnel. Finally, transfer often adversely impacts patient clinician relationships and clinical programs (whether medical, mental health, or dental oriented). Given the scope of overcrowding, however, and an unceasing need for more and more transfers, the present CDCR system functions in a manner whereby classification driven decisions are primary, with medical/mental health/dental issues assuming a secondary and in [17] every instance unacceptably low level of importance.

2. *The Scope of Prisoner "Moves."*

Given the State's decision to construct very large correctional facilities and given the decision to site many prisons in remote locations, it is not surprising that CDCR effectuates hundreds of thousands of prisoner moves each year. Movement into and out of the CDCR, as well as between CDCR prisons has now reached crisis proportions. For example, Exhibits 10 through 12 provide a prison-by-prison summary of inmate movement into and out of specific institutions, as well as a systemic total, for the months of January, February, and March 2007.[8] In total there were *more than 170,000 prisoner moves during the first quarter of calendar year 2007 alone*. CDCR reception centers were especially hard hit. For example, the California Institution for Men ("CIM"), a male reception center, averaged *more than 11,000 prisoner moves each month*.

3. *Mission Change and "Yard-Flips."*

In addition to an increasing velocity of prisoner movement and its adverse impact on attempts to deliver constitutionally adequate medical care, correctional officials in the CDCR are forced, because of the pressures of overcrowding, to constantly re-evaluate the correctional mission of each CDCR institution and to periodically alter those missions in order to provide housing for classifications of inmates for whom bed shortages have become especially acute.

Yard flips (a procedure whereby housing units or yards within a prison are designated for a different classification of prisoner) and mission changes (a procedure whereby an entire prison is designated for a different classification of prisoner) exemplifies yet another characteristic of California prison overcrowding: *the real life impact of crowding is not only in the overall numbers, but also in the population*

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[8] Official CDCR statistics are reported by counting a prison transfer "out" and the resulting prison transfer "in" (at a different institution) as only one move. However, because both the transfer out and the transfer in require some form of health care intervention, this report totals all moves.

pressures created by a lack of beds for specific classifications of prisoners. For example, an increase in long term violent offenders classified as [18] Level IV prisoners requires an increase in celled housing. An increase in short term non-violent offenders calls for increased housing in dormitories/lower security housing.[9]

Yard flips and mission changes are necessitated by classification related housing shortage. In essence, one classification of prisoner is moved out of a specific yard or prison and transferred to other institutions while a different classification of prisoner is moved into those units. Exhibit 13 summarizes CDCR bed conversions from February 2003 through May 2007.

It is important to emphasize that with increasing overcrowding, yard flips and missions changes have become an unceasing process. *See*, for example, Exhibits 14 - 16, three CDCR Memorandums issued the same day - March 30, 2007. The first calls for 11 emergency revisions to previously issued "Institution Activation Schedules," the second converts Facility D of the California State Prison at Los Angeles County ("LAC") from a Level IV General Population housing unit into a Reception Center, and the third converts Centinela State Prison from a Level III prison to a Level IV prison.

4. *The Heightened Negative Impact of Overcrowding on CDCR Reception Centers.*

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[9] As explained below, when analyzing the impact Assembly Bill 900, creating additional CDCR dormitories will not address the crisis shortage of Level IV cells.

Because of overcrowding, the Plan of Action faces special challenges relative to CDCR reception centers. For example:

1. One of the factors driving California prison overcrowding is the State's failure to implement rehabilitation programs. Therefore, in California, high percentages of paroled prisoners either "violate" their conditions of parole or "re-offend" with a new crime.

2. Thus CDCR reception centers have, during the past twenty years, encountered ever increasing prisoner movement pressures as more and more prisoners flow into the CDCR for relatively short terms of incarceration. As demonstrated by Exhibits 10 - 12, this flow into the CDCR has a special impact on reception centers such as CIM, SQ, the Deuel Vocational Institute ("DVI").

[19] 3. Reception centers are institutions which must be staffed and have the appropriate clinical space to provide a level of medical care and clinical evaluations above that of the general population institutions. When a former prisoner violates parole or re-offends, he or she returns to the CDCR through a reception center where a medical/mental health/dental health care appraisal must be performed. Once that appraisal is completed the newly received prisoner is transferred to an open bed at a prison which has been designated for his or her classification. However, none of the CDCR's designated reception centers were designed or constructed with adequate clinical space. To make matters worse, as the original prisons designated for reception became overwhelmed by the influx of parole violators, the CDCR was forced to "convert" general population prisons into reception centers. These "conversions,"

however, were not accompanied by adequate additions to clinical staff or clinical space. For example when San Quentin, the State's oldest prison, converted to a reception center it was allocated an entirely inadequate temporary relocatable structure, which until the Receiver began his San Quentin Pilot Project, had not been renovated or replaced.

The degradation of CDCR reception process continues to this day. As Exhibit 15 demonstrates, because of overloads at other reception centers, slowly but surely, yard by yard, LAC is mutating into a full blown reception center. Although chapels and libraries have been converted into some additional clinical space, LAC has neither the staffing nor the clinical space to accomplish the health care elements of reception.

G. The State's Failure to Plan, Design, and Build Appropriate Clinical Space In Its Newest and Most Modern Prisons.

The Receiver has discovered that the Plan of Action, as it relates to overcrowding, cannot assume adequate prison medical clinics/treatment area infrastructure exists even in California's newest and most modern prisons. To the contrary, when measuring the impact of overcrowding on his remedial efforts, the Receiver is forced to consider the following two facts:

(1) the newest CDCR prisons were designed with clinic space which is *only one-half that necessary for the real-life capacity of the prisons*; and

[20] (2) while millions of dollars have been allocated for prison health care space projects during the past five years, the great majority of the

project were never completed; indeed, some projects do not appear to exist.

1. *Inadequate Clinical Support Space in the State's Newest and Most Modern Prisons.*

In the beginning of the prison construction boom in the early 1980s, the CDCR developed a "Prototypical Prison Policy Design Criteria." (Exhibit 17.) This policy has been revised over the years and continues to reflect CDCR and the State's policy on what will be built at each new prison. In 1988 the policy was revised to clearly reflect the reality of overcrowding in the prison system even at that time The policy states that at Level II, III, IV and reception centers, certain functional areas of the new prison will be built to accommodate 130 percent overcrowding. Those functional areas included *only* personnel, accounting, inmate records, procurement, receiving and release and family visiting. The policy goes on to mandate that the infrastructure at new prisons, (which includes *only* water, wastewater, electrical, mechanical) will be designed to accommodate 190 percent overcrowding in celled prisons and 140 percent overcrowding in dormitory prisons. Thus, at a policy level, by default, the CDCR short-changed by at least 50% all health care related space needs.

Therefore, while the overcrowded populations of the modern facilities approach or exceed two hundred percent, and regardless of how the CDCR attempts to characterize the level of crowding, the available clinic space is *one half of what is necessary for daily operations.*

This CDCR policy and practice, for more than twenty years, to limit health care space, including staff offices, examination/treatment rooms and medical beds, to only the base staffing level of the institution, ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity, adversely impacts the daily medical, mental health, and dental operations at the following prisons.

1. Avenal State Prison
2. California State Prison-Calipatria
3. [21] California State Prison-Centinela
4. California State Prison-Corcoran
5. California State Prison-Solano
6. Chuckawalla Valley State Prison
7. California State Prison-Sacramento
8. High Desert State Prison
9. Mule Creek State Prison
10. Ironwood State Prison
11. Kern Valley State Prison
12. California State Prison-Los Angeles County
13. North Kern State Prison
14. Pelican Bay State Prison
15. Pleasant Valley State Prison
16. R.J. Donovan Correctional Facility
17. Substance Abuse Treatment Facility
18. Salinas Valley State Prison
19. Wasco State Prison

2. *A Case Study of How CDCR Construction Planning Ignores the Crowding Related Clinical Space and Staffing Needs of the CDCR Health Services Program - Kern Valley State Prison.*

Kern Valley State Prison ("KVSP"), the CDCR's newest prison, opened in June of 2005, was built to a standard of "base staffing", except for water, wastewater, electrical, mechanical. (Exhibit 18.) To summarize, absolutely no consideration was given to the real life impact on the prison's health care program that would result by the CDCR's plans to immediately double cell the entire prison. As a result of this policy, at KVSP the health care space on each of the four semi-autonomous facilities was limited to accommodate *one* Primary Care Provider's office based on the ratio of 1 doctor for every 500 inmates. Each of the four facilities was also built [22] with one Examination/treatment room, a medication distribution/sick call window, and a dental operatory/office.

Likewise, in KVSP's Central Health Care Services space the number of "infirmary beds" was determined by the prison's "design" bed capacity, even though CDCR officials knew before the construction began that the prison would be overcrowded. A Correctional Treatment Center ("CTC") was subsequently constructed in lieu of infirmary beds. KVSP has a design capacity of 2,448 inmates. Based on the CDCR's space standards this would then require KVSP to have 1 medical bed for every 125 inmates for a total of 19 beds. In fact KVSP has a total of 24 CTC beds. However, KVSP now confines not 2,448 inmates but, as of April 4, 2007, 4,952 inmates (202.3 percentage of overcrowding).

Based on the level of overcrowding at KVSP they should have at least 38 medical beds in order to accommodate the inmate-patient needs. Likewise KVSP now needs, even under the CDCR's own standards (which the Receiver finds inadequate as explained below) twice the number of clinical offices, clinical space, and infirmary beds as presently exist. In essence, KVSP was planned, designed, and subsequently constructed knowing full well that the medical, mental health, and dental space and staffing would be entirely insufficient for the prison's actual population.

3. *Millions of Dollars Allocated for Prison Health Care Space Projects and Little to Show for It.*

A summary of health care services Capital Outlay projects for the past five fiscal years is set forth in Exhibit 19. This information is significant when evaluating CDCR efforts to address the pervasive lack of health care space within its prison system. As stated above, each and every prison approved, funded and built by the State over the past twenty plus years was constructed to only accommodate "base staffing" only – except for infrastructure, water, wastewater, electrical, mechanical and certain other functions (such as receiving and release, family visiting, and accounting). The policy to build only to base staffing levels has left the CDCR in crisis regarding the clinical space needed to provide constitutional levels of access to health care.

[23] In a small effort to attempt to improve this flawed system, CDCR had obtained in the past five years approval to go forward with a limited number of health care space projects. For example, in fiscal year 2002/03 a total of $6.917 million was approved,

one-third of which was for a Ambulatory Care Center at CMF, which has in fact been completed. Many other projects, however, such as $375,000 allocated for a CTC at SQ and $1.9 million for a "Hospital" at DVI have not come to fruition. SQ does not have a CTC, nor does DVI have a hospital. Unfortunately, the CDCR construction program has a tendency to invest significant funds for the planning of projects which fail to come to fruition. For example, in fiscal year 2003/04 Ironwood State Prison ("ISP") received approved for an expenditure of $3.8 million for the completion of a CTC. These funds were in addition to $50,000 approved in 2002/03. As of this date the CTC has not been completed, as of today it does not house a single inmate or provide any health care services to inmates at ISP. Likewise, during fiscal year 2004/05 $1 million was approved for a nineteen chair dialysis center at SATF. The construction has finally, years later, been completed; however due to litigation over the contracting-out for the dialysis services, the operation of the chairs is not fully implemented. In fiscal year 2006/07 $2.5 million was approved for a "Hospital" at DVI, in addition to a fiscal year 2002/03 allocation of $1.9 million. After inquiries, the Receiver's staff were informed that this particular CDCR allocation is in fact controlled by the Department of General Services for a "seismic retrofit" of an "infirmary building." The Receiver has not approved this project; in fact, he was not aware of it until the preparation of this report, despite the allocation of $4.4 million.

In addition to the above projects, each year the CDCR has been allocated approximately $5 million for "Minor Capital Outlay" projects. These funds were allocated on a priority basis as determined by CDCR officials. Through this process, some CDCR institutions have received funds to provide additional health care space. For example, at Wasco State Prison a triple-wide trailer has been added for clinician office space, primarily utilized by mental health staff. A new health care building has been constructed next to the existing Central Health Clinic at Avenal State Prison, which, unfortunately, is located hundreds of yards of away from inmate housing [24] units. This space is primarily utilized for staff offices. At California State Prison Solano, a building was constructed on the Facility IV grounds approximately eight to ten years ago, to be utilized by mental health staff. In 2006 at R.J. Donovan custody staff moved out of their offices for use by health care staff, and a trailer has been placed in a plaza area for use as additional health care offices. At Sierra Conservation Camp ("SCC") an office has been converted into a telemedicine clinic, and at Mule Creek State Prison a former vocational area on Facility B has been converted into mental health clinics and offices. Nevertheless it cannot be disputed that, based on the CDCR budget of the last five years, very little health care space has been added to any of the prisons which now confined at least twice as many inmates as they were designed to hold.

IV.

THE MANNER IN WHICH OVERCROWDING INTERFERES WITH THE RECEIVER'S ABILITY TO SUCCESSFULLY IMPLEMENT TIMELY PROGRAMS WHICH WILL REMEDY THE UNCONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

Overcrowding interferes with the Receiver's ability to successfully remedy the constitutional violations at issue in two significant ways: (1) substantive interference; and (2) process interference.

B. Crowding Related Substantive Interference With the Receiver's Remedial Programs.

As explained in the Plan of Action, in order to implement adequate and sustainable programs which will bring California's prisons up to constitutional standards of medical delivery, the Receiver needs to both establish the necessary correctional care infrastructure and to implement time phased, coordinated medical delivery programs. Overcrowding will inhibit this process in a number of significant ways.

1. *Crowding Related Obstacles to the Recruitment, Hiring, and Retention of Competent Medical Personnel.*

The Receiver's top priority during the next two years will involve recruitment, hiring and [25] the implementation of orientation and training programs to improve retention of necessary clinical staff (including physicians, mid-level providers, registered nurses, licensed vocational nurses), as well as support staff ranging from information technology staff to office assistants. Overcrowding adversely impacts this efforts in three ways:

a. The long-standing nature of California's prison overcrowding and the CDCR's policy of deliberately short changing the need for clinical space, combined with crisis levels of staffing shortages creates adverse barriers to the Receiver's ability to recruit and retain necessary, competent medical care staff. The Receivership will be building from "the ground up" a medical delivery system within a prison culture where what should be a relatively simple task – bringing a patient to a prison clinic – presents an almost insurmountable challenge because the number of patients who need care far exceeds the number of correctional officers available for escorts. Concerning some of the most basic elements of an adequate medical delivery system, the Receiver has found that the State's long standing acceptance of overcrowding, combined with staffing shortages, has created a culture of cynicism, fear, and despair which makes hiring and retaining competent clinicians extremely difficult.

b. The total number of clinicians and support staff needed because of the present levels of overcrowding is far above the number that would have been needed if all CDCR prisons operated at their design capacity. For the same reasons, the difficulties that would have been faced recruiting competent medical providers for the CDCR's remote prisons is also intensified, requiring necessary but costly remedial programs such as developing an air force to transport physicians out of urban areas to and from work assignments in rural prisons.[10]

c. Some of the special characteristics of California prison overcrowding will require [26] significant numbers of additional clinical personnel. For example, the number of additional clinical staff that will be needed at CIM to provide health assessments, monitor medical records, provide follow-up care, and ensure that appropriate medications are provided for more than 12,000 inmate moves each month will be significant to say the least.

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[10] In similar fashion, overcrowding will render other infrastructure programs set forth in the Plan of Action more difficult to effectuate. For example, an increase in the number of clinicians needed to care for prisoner/patients will require an increase in the number of computer terminals that will eventually be installed as part of a new information technology system. Likewise the number of medical records needs to increase as the inmate population increases, and therefore additional space must be constructed for medical records. In similar fashion the amount of medical supplies must be increased, as well a pharmacy services, etc.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention programs will increase significantly because of overcrowding. In some rural counties, the number of clinicians and support staff needed to bring local prisons up to constitutional standards may well require additional salary increases for CDCR clinicians and a resulting disruptive impact on the availability of clinicians for county and private health care programs.

2. *Crowding Related Obstacles Re the Development of Competent Managers and Executives.*

In similar fashion, overcrowding has an adverse impact on the Receiver's ability to recruit and retain competent health care managers and executives. As the Court is aware the Receiver has filed a motion to establish Receiver Career Executive Assignment ("RCEA") positions. Given on-going intensification of overcrowding, not only will the recruitment of such personnel be more difficult, but the larger the remedy, the more managers and executive who will be necessary.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention of managers and executives will increase significantly because of overcrowding.

3. *Crowding Related Obstacles Preventing the Establishment of Constitutionally Adequate Reception Center And Inter-Prison Transportation Procedures.*

The stipulated *Plata* injunction, as set forth above, calls for adequate reception center health care appraisals and the appropriate programs to protect prison medical conditions during inter-prison transportation. However the present velocity of prisoner movement into and out of reception centers as well as between prisons creates a serious obstacle to meeting these [27] objectives. Given present conditions, hundreds of additional "budgeted" correctional officers and clinical staff will be required to appropriately manage the hundreds of thousands of inmate moves that take place every year, not to mention a vast fleet of transportation vans and escort vehicles.

To summarize, the cost and duration of the remedial effort of the Receiver's programs for adequate reception centers and inter-prison transportation practices will increase significantly because of the velocity of prisoner movement in the CDCR.

4. *Crowding Related Obstacles Concerning Provisions for an Adequate Number of Health Care Beds.*

An adequate number of different levels of medical care beds are an absolutely necessary component of the Plan of Action. Overcrowding presents an obstacle to achieving this objective because, as explained by the Receiver in his bimonthly reports, three different types of additional construction will be necessary:

1. The addition of approximately 5,000 new medical beds to provide the appropriate treatment, care,

and sheltered living for CDCR prisoner/patients. To a significant degree, these beds are necessary because the CDCR has neither planned for nor provided adequate medical beds for disabled prisoners, aged inmates, and prisoners who need some form of sheltered living due to their medical or mental health conditions.

2. The construction of an as yet undetermined amount of additional clinical space at existing CDCR prisons, primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200 percent of design capacity.

3. The construction of an as yet undetermined amount of clinical offices, medical records storage areas, medical supply warehouses, etc., primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200 [28] percent of design capacity.

To summarize, the cost and duration of the remedial effort of the Receiver's construction programs will increase significantly because of overcrowding.

5. *Crowding Related Obstacles Concerning Medical Delivery Support Services.*

California prison overcrowding will also impact those elements of the Plan of Action which provide for necessary medical support services. For example, the Office of the Receiver is presently involved with a program to completely restructure the CDCR's medical contracting process. Very positive initial results have been achieved. However an increasing number of prisoners in the more remote prisons has placed a heavy burden on a very limited number of hospitals and speciality providers which in turn has created obstacles in the Receiver's efforts to achieve a more efficient, patient oriented, and less wasteful contracting process. Overcrowding presents similar obstacles to other support services. For example, the use of telemedicine should be, and will be expanded for both improved patient care and cost containment purposes. However, even the most simple of necessary expansion steps; for example, finding a room adequate for telemedicine purposes often presents an unsurmountable barrier because California's prisons were constructed without adequate clinical or office space for the numbers of inmates housed at the prison.

To summarize, the cost and the duration of the remedial effort of the Receiver's Plan to implement necessary medical care support services will increase significantly because of overcrowding.

C. Crowding Related Process Interference With The Receiver's Remedial Program.

1. *Introduction.*

Every element of the Plan of Action faces crowding related obstacles. Furthermore, overcrowding does not only adversely impact the Receiver's substantive plans, it also adversely impacts on the very process of implementing remedies because overcrowding, and the resulting day to day operational chaos of the CDCR, creates regular "crisis" situations which call for action on the part of the leadership of the Receivership and take time, energy, and person power [29] away from important remedial programs. Examples of crowding related crisis/chaos situations which impact on Receivership's remedial activities include the following.

2. *Out of State Transfers.*

The Receiver and his staff worked in a diligent manner to support the Governor's efforts to effectuate out of state transfers. This effort required the implementation of a formalized health screening process; training nursing staff on screening; allocating staff to conduct screenings; allocating staff to inspect the private out-of-state prisons where CDCR prisoners would be confined; and reviewing contracts with private prisons to ensure that mechanisms existed to provide compliance with Court orders, etc. Suddenly, however, the process was halted due to State Court decisions. Recently, however, plans for out of state transfers have begun again due to the passage of Assembly Bill 900, although questions apparently remain concerning future State Court processes. Starting, then stopping, and then restarting these support efforts must be managed in a careful manner so that the Receivership does not begin to experience the day to day chaos which afflicts the CDCR.

3. *Responding to Mission Changes and Yard Flips.*

In a similar manner, the Receiver has attempted to work with CDCR concerning the various mission changes and yard flips associated with increased overcrowding. However it has been necessary on occasion to stop changes which would have put prisoner/patients in increased jeopardy of receiving inadequate medical care. Needless to say, monitoring mission changes and yard flips has become a full time activity. It may be necessary for the Receiver to provide direct oversight over CDCR yard flips and mission changes at some time in the future should this problem further exacerbate efforts to implement the Plan of Action.

4. *Disturbances.*

CDCR reports an increasing number of overcrowding related prisoner disturbances. Most disturbances are followed by prisoner "lock downs," and on occasion the lock downs are protracted. Lockdowns call for a radically different form of medical delivery than the services provided under normal general population conditions. Under normal operating procedures, [30] inmates housed in general population leave their housing units to go to yard clinics to see medical providers, to receive medications, etc. Under lockdown conditions, clinical staff must go from cell to cell to see the prisoner/patient, or small groups or individual prisoners must be escorted by correctional officers to and from clinic areas. In either case, lockdowns inhibit the delivery of medical care and increase the staffing necessary for such care. As crowding related disturbances increase, the Receiver may need to modify the Plan of Action in order to establish special clinical and correctional officer staffing standards for those institutions which function under lockdown conditions on a regular basis.

5. *Infectious/Communicable Disease Management.*

As reported in the Fourth Bi-Monthly Report, overcrowding has increased the number and seriousness of infectious and communicable diseases, jeopardizing prisoners, staff, and the public. Thus far system wide outbreaks have been avoided, however, given the number of prisoners, conditions in gyms and hallways converted to housing units, the velocity of prisoner movement between institutions and in and out of the CDCR itself, the risk of such an outbreak cannot be underestimated.

6. *The Inability to Deliver Basic Health Care Services Due to Staffing Shortage and Increased Numbers of Inmates.*

Many CDCR prisons are unable to sustain the basic delivery of medical, mental health, and dental services because of limited staffing (clinical and custody) and an overwhelming number of prisoner/patients who require care. Every day, many California prison wardens and health care managers make the difficult decision as to which of the class actions, *Coleman, Perez, Armstrong* or *Plata* they will fail to comply with because of staff shortages and patient loads. This in turn creates crisis conditions (as described in the Fourth Bi-Monthly Report concerning Avenal State Prison) which, because it requires immediate attention, diverts the Receiver's resources from Plan of Action related activities.

7. *Class Action Coordination Issues Aggravated by Overcrowding.*

Overcrowding combined with twenty years of CDCR construction practices has created [31] competition and tensions between medical and mental health providers concerning use of clinical space. For example, because of the failure, for more than fifteen years, to provide an adequate number of inpatient beds for prisoners with very serious mental illnesses, prison CTC beds confined many patients in a mental health "crisis" creating shortages of CTC beds for medical needs which, at times, pits medical staff against mental health staff. In similar fashion, the failure by the CDCR to plan for and construct beds for aged and disabled prisoners has lead to a practice of using the CTC beds for sheltered living housing, creating similar tensions. While these issues are being addressed in monthly coordination meetings between the Receiver, the Special Master in *Coleman*, and the Court experts in *Perez*, they present another series of serious, constant problems which divert attention from Plan of Action remedial programs.

The Receiver recognizes that he is responsible for a prison medical delivery system in crisis and therefore regular crisis situations, and the appropriate response, are to be expected. However, without question, overcrowding and the resulting chaos in the CDCR has an adverse impact on the Receiver's efforts to implement the Plan of Action, and the day to day problems created by overcrowding will increase both the cost and the duration of his remedial efforts.

V.

THE IMPACT OF ASSEMBLY BILL 900

A. Introduction.

This report would not be complete without the Receiver commenting on the possible impacts of Assembly Bill ("AB") 900. A summary of the bill follows.

B. Summary of AB-900.

Section 1. Name of Act.

Names act as "the Public Safety and Offender Rehabilitation Services Act of 2007."

Section 2. Prison Construction-Phase I

Requires the CDCR to add up to 7,484 beds at 10 specified prisons.[11]

Requires the CDCR to add an additional 4,516 beds after site assessments are completed [32] at other facilities:[12]

Requires that the above beds be supported by rehabilitation programming.[13]

Declares that purpose of new beds built under this phase is to replace "temporary beds"—not to house additional inmates:[14]

Authorizes construction of reentry program facilities for up to 6,000 inmates:[15]

Authorizes construction of new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 6,000 inmates."[16]

Subjects all projects to approval and administrative oversight of State Public Works Board.[17]

Authorizes the State Public Works Board to issue bonds to finance construction.[18]

Authorized costs for medical, dental and mental health construction are $857,100,000:[19]

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[11] Government Code 15819.40(a)(1)(A).

[12] Government Code 15819.401(a)(1)(B).

[13] Government Code 15819.40(a)(2).

[14] Government Code 15819.401(a)(3).

[15] Government Code 15819.40(b).

[16] Government Code 15819.40(c).

[17] Government Code 15819.401.

[18] Government Code 15819.403.

Section 3. Prison Construction-Phase II

In addition to the construction required in Phase I, authorizes the CDCR to construct 4,000 beds at existing prison facilities, and requires that such beds be supported by rehabilitation programming.[20]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 2,000 inmates."[21]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct reentry program facilities that will house up to10,000 inmates.[22]

Subjects all projects to approval and administrative oversight of State Public Works [33] Board.[23]

Authorizes the State Public Works Board to issue bonds to finance construction.[24]

Authorized costs for medical, dental and mental health construction under Phase II are $285,700,000.[25]

Provides that the board may not release funds for Phase II construction until a 3-member panel, composed of the State Auditor, the Inspector General and an appointee of the Judicial Council of Califor-

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[19] Government Code 15819.403.

[20] Government Code 15819.41(a).

[21] Government Code 15819.41(b).

[22] Government Code 15819.41(c).

[23] Government Code 15819.411.

[24] Government Code 15819.413(a).

[25] Government Code 15819.413(a).

nia, has certified that 13 specified requirements have been met.[26]

Authority provided for Phase II construction expires on January 1, 2014, but projects already commenced may be completed.[27]

Sections 4 & 5. County Jail Facilities

Relates to the financing and construction of county jail facilities, and authorizes the issuance of up to up to $750,000,000 in bonds for that purpose.

Authorizes the issuance of an additional $470,000,000 in bonds for county jail construction if the 3-member panel has certified that certain conditions have been met.

Section 6. Rehabilitation Incentives

Requires CDCR to implement a system of incentives to increase inmate participation in academic and vocational education.[28]

Section 7. Management Deficiencies

Requires CDCR to implement a plan to address management deficiencies.[29]

Section 8. Rehabilitation Plan

Requires CDCR to implement a plan to obtain additional rehabilitation and treatment services for prison inmates and parolees.[30]

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[26] Government Code 15819.417; Penal Code 7021.

[27] Government Code 15819.417.

[28] Penal Code 2054.2.

[29] Penal Code 2061.

[30] Penal Code 2062.

[34] Section 9. Inmate Payments; Report to Legislature

Requires CDCR to report to the Legislature on whether existing laws related to payments to inmates released from prison are hindering the success of parolees and resulting in their rapid return to prison for parole violations.[31]

Section 10. Substance Abuse Treatment

Requires CDCR to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates.[32]

Section 11. Interdisciplinary Assessments

Requires CDCR to conduct interdisciplinary assessments for the purpose of program placement.[33]

Section 12. Day Treatment and Crisis Care for Parolees

Authorizes CDCR to obtain day treatment, and to contract for crisis care services, for parolees with mental health problems.[34]

Section 13. Prison to Employment Plan

Requires CDCR to develop an Inmate Treatment and Prison-to-Employment Plan.[35]

Sections 14 & 15. OIG: California Rehabilitation Oversight Board

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[31] Penal Code 2713.2.

[32] Penal Code 2694.

[33] Penal Code 3020.

[34] Penal Code 3073.

[35] Penal Code 3105.

Creates within the OIG the California Rehabilitation Oversight Board, which will examine and report on CDCR mental health, substance abuse, educational and employment programs.[36]

Section 16. Reentry Program Facilities

Relates to the establishment and operation of the re-entry program facilities authorized in Phases I and II of construction described above.

[35] Section 17. Master Plan

Expands provisions defining facilities "master plan" to include the department's plans to activate or remove temporary beds in dayrooms, gyms, and other areas.[37]

Sections 18 & 19. Submission of Plans and Reports to Joint Legislative Budget Committee

Requires CDCR to submit to the Joint Legislative Budget Committee (prior to submissions of preliminary plans to the State Public Works Board) (1) a preliminary facility plan, (2) an operating cost estimate, (3) a staffing plan, (4) a plan for medical, dental and mental health care, and (5) a programming plan.[38]

Requires CDCR to submit annual and quarterly reports to the Joint Legislative Budget Committee regarding the status of funded projects, including medical, mental health and dental projects.[39]

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[36] Penal Code 6140 & 6141.

[37] Penal Code 7000.

[38] Penal Code 7003.

[39] Penal Code 7003.5

Section 20. Communication with Local Governments

Requires CDCR to meet with representatives of cities or counties related to new permanent housing units prior to CEQA review.[40]

Section 21. (Repeals]

Section 22. Phase II Construction Panel

Creates 3-member panel charged with verifying whether certain conditions have been met before the State Board of Public Works may release funds for Phase II construction.[41]

Section 23. Temporary Construction

Authorizes use of portable or temporary buildings for housing and rehabilitation programming.[42]

[36] Sections 24-26. Out-of-State Transfers

Temporarily authorizes (until 2011) out-of-state transfers of inmates, without inmate consent.[43]

Provides that "no inmate with serious medical or mental health conditions, as determined by the Plata Receiver, or an inmate in the mental health delivery system at the [EOP level of care or higher may be committed or transferred to an institution outside the state unless he has executed a written consent to the transfer.[44]

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[40] Penal Code 7004.5.

[41] Penal Code 7021.

[42] Penal Code 10007.

[43] Penal Code 11191(a).

[44] Penal Code 11191(b).

Section 27. Training Academy

Authorizes CDCR to establish a training academy for correctional officers in southern California.[45]

Section 28. Supplemental Infrastructure Capacity & Rehabilitation Funding

Appropriates $350,000,000 from the General Fund to CDCR for capital outlay to renovate, improve, or expand infrastructure capacity at existing prison facilities and to supplement funds for rehabilitation and treatment of prison inmates and parolees.

Section 29. Urgency Statute

Provides that Act goes immediately into effect.

C. CDCR Does Not Have An Adequate Plan to Create "In-Fill" Beds With the Necessary Support (Including Health Care Clinic) Space.

1. *Introduction.*

Following a first review by his staff of AB 900 and an evaluation of CDCR plans to implement AB-900, the Office of the Receiver can provided initial findings concerning possible impacts of the bill, as set forth below.

2. *Inadequate Space Allocations For Health Care Services.*

The CDCR's Infill Bed Plan is included as Exhibit 20. A summary of the space proposed to be allocated for health care space (medical, mental health, and dental) is attached as [37] Exhibit 21. As is apparent from the summary, the clinical space allocated to different prisons are wildly disparate, and in many cases obviously inadequate. For example, for clinical purposes, the proposed administrative segregation unit at Avenal (190 beds) is allocated 2,970 square feet of space, while the administrative segregation unit at Calipatria (190 beds) is allocated 2,127 square feet of space and the administrative segregation unit at Centinela (190 beds) is allocated 1,779 square feet of space.[46]

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[45] Penal Code 13602.1.

The Receiver has not been informed concerning what elements of the January 2007 Infill Bed Plan will be utilized under AB-900. Regardless, there exists a fundamental error in the manner in which CDCR has traditionally approached health care clinic construction (in addition to the past practice of allocating only one-half as much space as actually necessary given the real prisoner population intended for new prisons). CDCR allocates *space only*, ignoring the real life differences in clinical requirement based on the characteristics of the patient population, security level and escort officers requirements, the need for clinical privacy, equipment requirements, and other critical factors.

In terms of all future clinic construction, the Receiver believes that, consistent with standards promulgated by the National Commission on Correctional Health Care ("NCCHC") and because of the vast differences among facilities, design, number of facilities in any given prison complex, and the age of buildings, rather than specifying square footage adequate space will be based on a number of different standards including the type of service provided, the need for pharmacy services, equipment need, inmate classification, supply needs, examination services, etc. (Exhibit 22.)

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[46] In addition to requiring medical and dental treatment, inmates confined to administrative segregation require heightened levels of mental health care and monitoring. Historically, a very high percentage of CDCR suicides take place in administrative segregation housing units. Therefore it is essential that the planning and construct of administrative segregation housing provides for enhanced space for mental health clinical interview and staff offices. The January 2007 Infill Plan appears to ignore this.

3. *Inadequate Overall Health Care Space Allocations.*

It must be noted that the existing CDCR construction related space allocations for clinics [38] and clinical office space are inadequate. For example, the CDCR allocation of 60 square feet for a nursing station, given the need for examination equipment, escorts, records, etc. is grossly inadequate. Exhibit 23 provides a summary of certain of the major shortfalls of current CDCR allocations.

4. *Conclusion.*

The existing CDCR Infill Bed Plan, if allowed to be implemented without oversight by the Receiver, the Special Master in *Coleman*, and the Court representatives in *Perez* and *Armstrong* will jeopardize prisoner/patient care and have a serious adverse impact on the Receiver's ability to implement the Plan of Action in a timely and cost effective manner.

D. AB-900 Will Not Reduce the Number of "Temporary ("Ugly") Beds at the Ten CDCR Prisons Subject to AB-900.

Phase I of AB-900 identifies ten prisons that will have a total of 7,184 beds added to their design capacity. The stated intent of AB-900 is to build new prison capacity which will "replace the temporary beds currently in use, and they are not intended to house additional inmates." AB-900 defines temporary beds as "those that are placed in gymnasiums, classrooms, hallways, or other public spaces that were not constructed for the purpose of housing inmates."[47] The CDCR, in its Master Bed List refers to these same beds as "non-traditional overcrowding beds."

In order to determine if AB-900, if fully implemented as written will reduce the existing and overcrowding levels at these ten prisons, Exhibit 25 was created. The first column of this exhibit lists the ten prisons as specified by AB-900 followed by the current security level and number of "temporary beds". The third column sets forth the CDCR's proposed Infill Bed Plan for each of the ten prisons by security level. For example, at Pleasant Valley State Prison there currently exists 774 Level III "temporary" beds and 150 Level IV "temporary" beds. However, the CDCR Infill Bed Plan proposes to add only 600 Level II beds.

From what the CDCR has provided, it appears that the total number of beds that will be "replaced" as required by AB-900 will be limited to 472 reception center beds. Eight of the ten [39] prisons will have zero temporary beds replaced based on CDCRs In-Fill Bed Plan. Based on the fact that only 472 reception center temporary beds will be taken down per AB-900, the remaining 4,280 exiting temporary beds at these ten institutions will remain filled with inmates.

It may be possible to fill proposed Infill beds at these ten prisons with inmates from other prisons. However in Phase I of AB-900 the vast majority of the 7184 new beds being created are Level II beds

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[47] A summary of "temporary beds," also know as "ugly beds" is attached as Exhibit 24.

(4,300 beds). The movement of Level II inmates from other institutions' "temporary beds" into the new housing units may have a positive impact on the sending institutions, *but only if they are then prohibited from back filling those temporary beds.* However considering the CDCR's history and practice of filling all available beds, coupled with the fact that AB-900 does not prohibit such action, we should anticipate that CDCR will continue to house inmates in these temporary beds even *after inmates are moved to the ten institution's new housing units.* In reality, therefore, AB-900 will serve only to increase the number of prisoner/patients who will required medical, mental health, and dental care.

E. AB-900 Does Not Address The CDCR's Most Serious Need For Additional Prison Beds.

The Infill Bed Plan proposes total (Phase I and II) addition of 16,238 beds, of which 9,440 are Level II beds, which will have some impact on the severe crowding at lower level prisons. The Infill Bed Plan, however, does nothing to address the serious levels of crowding within the CDCR's most dangerous high security prisons.

The top chart in Exhibit 26 summarizes the CDCRs projected Male population needs by security level from fiscal year 2007/08 through fiscal year 2011/12.[48] The first column identifies the fiscal year, the second through the eighth columns identifies the security level, and the last column is the projected grand total of Male inmates. The CDCR projects that the Male population for all security levels except Protective Housing Unit will increase over the next five fiscal years. The greatest increase is projected to be at security level IV with 3,830 additional [40] Male inmates to be accommodated within the existing overcrowded institutions. Level IV prisoners are considered by the CDCR to be the most dangerous in terms of escape risk and potential for in-prison misbehavior.

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[48] This information was obtained from the CDCRs Spring 2007 Adult Population Projections 2007-2012 report.

The lower chart compares *only* the additional projected Male population needs with the CDCRs proposed In-Fill Bed Plan. Based on this comparison, there appears to be a significant disconnect between the CDCR's projected housing needs, especially in its most dangerous prisons, and what the CDCR is planning to build. For example, CDCR projects an increase of 3,840 Level IV inmates while the CDCR's Infill Bed Plan does not include a single Level IV bed. The same is true for Security Housing Unit (SHU) inmates with a projected increase of 425 inmates with no plan to increase the SHU beds by even one bed/cell.

Given current levels of overcrowding at two of the CDCR's Level IV and SHU institutions, a serious need for additional Level IV and SHU beds is clearly demonstrated. For example, as of April 4, 2007 Pelican Bay State Prison ("PBSP"), a SHU and Level IV institution was operating at 154.5% of design capacity. Salinas Valley State Prison ("SVSP") another Level IV institution as of April 4, 2007 was operating at 206.8% of design capacity. The failure to plan for additional Level IV beds based on the current level of overcrowding and the projected increase of Level IV and SHU bed needs, will create additional severe overcrowding within the CDCR's most dangerous and difficult to manage prisons at this time. If overcrowding intensifies in the CDCR's highest security institutions, the Receiver's effort to implement the Plan of Action will require more time and additional funding.

F. AB-900 Re-Entry Facilities.

AB-900 proposes to site and construct numerous re-entry facilities throughout the State. Each of those facilities will require clinical staff to provide intake and exit health care assessments. In addition, each facility will require on-site health care staff to delivery needed care. In essence AB-900 calls for a new set of institutions to be included in the existing Federal Court remedial plans. Given the record in this case, the Receiver must assume that adding more CDCR institutions will increase the cost and the time necessary to implement the Plan of Action.

[41] G. Staffing.

It is easy to talk of constructing prisons and jails. It is more difficult and expensive to staff correctional institutions with the appropriate clinical personnel and correctional officers. AB-900, however, is silent about how the jails and prisons beds cited in the bill will be staffed and managed. Unless and until adequate staffing is provided, the Receiver anticipates that the additional beds proposed in AB-900 institutions will increase the cost and the time necessary to implement the Plan of Action.

VI.

CONCLUSIONS

The Receiver summarizes his best assessment of the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations as follows:

1. The Receiver's Plan of Action will work. Failure is not an option. Over time the CDCR's medical delivery system will be raised to constitutional levels. However, the time this process will take, and the cost and the scope of intrusion by the Federal Court cannot help but increase, and increase in a very significant manner, if the scope and characteristics of CDCR overcrowding continue. For example, the Receiver can, over time and with great expense, develop a reception center medical delivery system that will appropriately handle the more than 11,000 prisoner moves into and out of CIM each month. The cost of such effort, however, may all but bankrupt the State of California and create a medical delivery problem in Riverside and San Bernardino counties because there may not be enough competent clinicians to both provide medical care for an unlimited number of State prisoners and for the public also. Thus, when the Court considers the issue of intrusion relative to controlling overcrowding, it should also consider the scope of intrusion that will be necessary to provide constitutionally adequate medical care in California's prisons if overcrowding is not managed.

2. The manner by which overcrowding is managed will have a fundamental and perhaps irrevocable impact on the Plan of Action. For example, if the State's response is limited to [42] effectuating out of state transfers, and thereafter filling empty beds behind departed prisoners, the overcrowding related challenges to the Plan of Action will only increase and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue. Likewise, if the State charges off to construct infill beds in remote locations without adequate support services space, including adequate clinical space,

overcrowding related challenges to the Plan of Action will only increase, and as a result, it will take the Receiver longer and it will cost more to correct the constitutional violation at issue. Finally, unless steps are taken to stop the revolving door of a failed parole system and thereby manage the out-of-control number of prisoner moves, the churning related challenges to the Plan of Action will continue and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue.

3. Finally, and perhaps more important, it is critical that the Court and counsel understand that the motion for a three judge panel can be separated and distinguished from the fundamental challenges faced by Receivership. While the attorneys for plaintiffs have filed three separate requests for a three judge panel in three different cases, it is important to emphasize that even if a three judge panel is appointed and even if the California prison system is, over time, capped, and even if its population is reduced by, for example, twenty-five percent (thereby releasing from existing housing units as many as 42,500 prisoners), the challenges faced by the Receiver and the Courts in *Armstrong*, *Coleman*, *Perez*, and *Plata* would remain a daunting one: to provide constitutional levels of prison health care for 125,000 prisoner/patients who will remain confined thirty-three inadequately constructed prison that function far above their correctional design capacity. Thus, even when assuming some form of population management, it will take years of effort and significant State resources to address the prison health care problems faced by the Federal Courts in California at this time.

To summarize, those who believe that the challenges faced by the Plan of Action are uncomplicated and who think that population controls will solve California's prison health care problems, are simply wrong. Population limits may help effectuate a more timely and cost effective remedial process. However, the cure to existing health care problems will be difficult [43] and costly to implement, regardless of population control efforts.

4. The following remedial actions in *Plata* are warranted now:

a. The CDCRS "in-fill" bed project, if allowed to proceed without oversight by the Receiver may well jeopardize prisoner patient health care. The Receiver recommends that the Court issue an order compelling the Secretary of the CDCR to file, within fifteen days, a report to this Court and to the *Armstrong*, *Coleman*, and *Perez* Courts concerning all aspects of the "infill" project, *including all studies and expert reports* that have been conducted relative to the issue of whether adequate space exists to construct additional non-medical beds with the appropriate support services, including clinical space. The Receiver has reviewed prior CDCRS submissions and recommends that the order should specifically require an executive summary of all proposed infill programs not to exceed ten pages.

b. The CDCR's long standing failure to hire an adequate number of correctional officers jeopardizes prisoner patient heath care. The Receiver recommends that the Court issue an Order to Show cause compelling the Secretary of the CDCRS to file, within fifteen days, a response as to why the Receiver should not begin to provide direct oversight over the CDCR's correctional officer recruitment and hiring program.

c. The Office of the Governor will be filing responsive pleadings to the Court's February 15, 2007 Order concurrently with this filing by the Receiver. The Receiver recommends that the Court consider whether the Governor should create his Plan of Action concerning how California will address the serious correctional problems afflicting the CDCR. Thus far, the Governor has worked to encourage the initial successes of the Receivership; however, for the Receiver's Plan of Action to be implemented in the most timely and cost effective manner possible, the State should develop a CDCR Plan of Action. As pointed out in this report, the CDCR's lack of planning, the day to day chaos within the CDCR, and its long standing failure to effectively perform basic correctional functions including prison construction and correctional officer hiring jeopardize prisoner patient medical care. The development of and adherence to a complementary correctional Plan of Action will enhance efforts by the Federal [44] Courts to bring California's prison health care up to constitutional standards of access and quality and will thereby hasten the return of the system back to the State.

Dated: May 14, 2007.

/s/ Robert Sillen
Robert Sillen
Receiver

[1] UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA AND THE EASTERN DISTRICT OF CALIFORNIA

Case No. CO1-1351 THE (N.D. Cal.)

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Case No. CIV S-90-0520 LKK JFM P (ED. Cal.)

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

RECEIVER'S SUPPLEMENTAL REPORT RE OVERCROWDING

Receiver Robert Sillen submits this Supplemental Report Re Overcrowding, and accompanying Declaration of John Hagar, in response to this Court's Orders, dated February 15, 2007 and June 6, 2007.

A. *Summary of Key Features of The Receiver's Report Re Overcrowding.*

In his original Overcrowding Report, filed herein on May 14, 2007, the Receiver set forth in detail a history of the overcrowding crisis in California's prisons; described the manner in which overcrowding exacerbated the failings in the prison health care delivery system; and then discussed how overcrowding – and the State's inadequate and inconsistent responses to that [2] overcrowding – are currently interfering with the Receiver's mission to bring the medical care delivery system up to constitutional standards.

In particular, the Receiver identified five "Crowding Related Obstacles" that were and are interfering substantively with his efforts to bring the prison health care system up to constitutional standards in a timely fashion.

1) Overcrowding is interfering with the Receiver's ability to recruit, hire and retain competent medical personnel. The overwhelming number of prisoners needing care at the prisons, existing staffing shortages and inadequate clinical space are just a few of the consequences of overcrowding that make developing a competent medical staff a daunting challenge.

2) For many of these same reasons, overcrowding will make hiring competent managerial and executive staff more difficult.

3) One of the consequences of overcrowding has been extraordinary movement of prisoners between and among the prisons. A downstream effect of this movement is the need for

many more correctional and clinical staff to manage reception center and inter-prison transportation procedures insofar as they relate to health care. That staff is currently lacking and, as a result, the rapidity of movement between prisons is continuing to create chaos in the health care system.

4) There is a dire need for additional clinical space and medical beds in the prisons because the existing capacity has been swamped by the number of inmates in the system. Until additional and adequate clinical space is constructed to accommodate the real needs of the prison population, the Receiver's work will be made significantly more difficult.

5) The overcrowding crisis has also interfered with the Receiver's ability to provide medical support services. Large numbers of prisoners needing care in outlying and remote areas often mean that CDCR must contract out for services that can, and should, be provided internally. Looking outside the prisons is in turn stressing local community health care systems. Similarly, overcrowding means inadequate space for [3] programs such as telemedicine that, if properly used, could result in better care at less cost.

The Receiver also emphasized in his Report that overcrowding creates "procedural" obstacles to the work he and his staff are undertaking. He highlighted six areas to illustrate how the day-to-day work of the Receivership is hampered as a result of overcrowding.

1) The State has responded to overcrowding by attempting to transfer prisoners out of state. The Receiver has endeavored to cooperate with this process. But, because of litigation, the passage of AB 900 and other factors, the transfers have started, and stopped, and started again, resulting in inefficiencies and frustration.

2) The State has responded to overcrowding by so-called "mission changes" and "yard flips" which result in large numbers of prisoners and different classes of prisoners being moved between prisons. Staff resources that the Receiver could allocate elsewhere are being consumed by the need to monitor and respond to mission changes and yard flips.

3) Overcrowding has resulted in increasing numbers of prisoner disturbances and "lock-downs" by prison authorities in response. Because of the heightened security measures associated with lockdowns, medical care to the inmates is delayed and made substantially more time-consuming and cumbersome.

4) The risk of communicable disease outbreaks in the prisons, as well as their transference to local communities is increased substantially by overcrowding and the attendant rapid movement of prisoners between prisons. The Receiver must devote significant staff resources to protecting against the possibility of disease outbreaks in such circumstances,

5) The extent of overcrowding in the prisons means that the entire health care system medical, dental and mental health – is

increasingly burdened. Because of staffing shortages and the overwhelming number of prisoners needing care, prison staff often must decide with which set of class action remedial orders they will comply at the expense of others. That creates inevitable crises and tensions all their own that must [4] require Receivership resources to address.

6) Related to the foregoing, the inadequacies in the health care system have resulted in tension and competition between the various providers over resources, space, beds and the like. Although the Receiver, special master in *Coleman* and court representatives in *Perez* and *Armstrong* are meeting regularly in an effort to coordinate their respective functions, overcrowding creates additional burdens on an already stressed system.

The Receiver concluded his Report by recommending that the Court enter three specific orders: (1) require the CDCR to file a report in 15 days, with supporting documentation and a brief executive summary, setting forth the CDCR's plan with respect to the "infill" project, particularly as it relates to the construction of additional clinical and non-clinical space; (2) issue an Order to Show Cause why the Receiver should not assume direct oversight of the correctional officer recruitment and hiring program and require the CDCR to respond in 15 days; and, (3) require the Governor to create a Plan of Action to address the serious correctional problems endemic to the CDCR.

B. *Recent Developments Further Illustrate The Substantive And Procedural Burdens On The Receivership Caused By Overcrowding.*

The consequences of severe overcrowding in the prisons, including specifically the CDCR's disorganized response to overcrowding, have continued to divert the Receiver's resources from his primary task of building a constitutionally adequate health care system. As a result, the Receiver concluded that he should bring to the Court's attention additional information that has arisen since the filing of the Receiver's Report and that further illustrates the impact of overcrowding on his remedial plans. That information is set forth in detail in the Declaration of John Hagar ("Hagar Decl."), filed herewith, and is summarized below.

1. *The "Mission Change" at California Rehabilitation Center ("CRC") Norco To An All Male Level II Prison.*

CRC consists primarily of wooden barracks and support buildings constructed prior to World War II. Until recently, CRC provided rehabilitation services to male and female drug [5] offenders. In April, 2007, the CDCR announced that CRC would transfer its female population and, thereafter, would house only male offenders. *See* Exh. 1 to Hagar Decl.[1] According to CDCR, more than 600 female prisoners will be removed from CRC by June 28, 2008. An unspecified number will be sent to Community Correctional Facilities ("CCFs") and the remainder will be placed into "ugly beds" (day room floors, hallways, and gyms) at the California Institute for Women ("CIW"),

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[1] Unless otherwise indicated, all Exhibit references are to the exhibits attached to Mr. Hagar's declaration.

California Central Women Facility ("CCWF"), and Valley State Prison for Women ("VSPW").

Although the CDCR planned these transfers as early as February 2007 and understood that the Receiver's approval and support would be required before the transfers could be accomplished (Exh. 2), the Receiver was not given sufficient notice of the contemplated changes to permit him to provide substantive input on the impact that the changes would have on the delivery of health care. In fact, specific information about the conversion was first provided to the Receiver's staff at a meeting on May 24, 2007. By that time, the movement of hundreds of female prisoners from CRC had already begun.

The conversion could have adverse impacts on the delivery of health care at CRC. The clinical space at CRC is already woefully inadequate and structurally unsound. For example, a new digital x-ray machine purchased by CDCR cannot be installed due to the fact that the flooring at CRC cannot bear its weight. Any additional medical demands at the facility as a result of the influx of Level II inmates may swamp an already stressed health care delivery system. Despite the significant changes contemplated at CRC, CDCR officials have indicated that no provision has been, or will be, made to improve or increase clinical areas at CRC.[2]

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[2] The Receiver's staff managed to head off a disaster in the making as a result of the conversion at CRC. Several years ago, CRC was approved for a dormitory replacement project. The plans called for the construction of new 200-bed dormitories, each of which was to replace two older wooden dormitories. The first of the new dormitories is scheduled to be operational in September 2007, the second in March 2008. However, at the meeting on May 24, CDCR officials suggested that the 200-bed

Nor have the Receiver and his staff had adequate time to evaluate the impact on health [6] care delivery at the receiving prisons as a result of the-mass transfers of women prisoners from CRC. Undoubtedly, the changes will have significant, negative consequences at the receiving prisons. For example, VSPW is already at a crisis stage insofar as efforts to provide medical care are concerned. An influx of new prisoners because of the conversion at CRC may well cause the medical delivery system at VSPW to collapse entirely. As Dwight Winslow, Statewide Medical Director at DCHCS wrote in an e-mail to the Receiver, dated May 24, 2007:

> . . . I got a call form [sic] Dawn Martin at VSPW this am and they are being overwhelmed with the influx of inmates and custody has closed down some of the off site transportation which is now causing a delay in care. She stated that they were at 200% of capacity and that there were inmates on the floors. She does not know how she is going to deliver care to these inmates.

Exh. 3.

The conversion at CRC will also result in potentially negative impacts on the delivery of mental health care in the receiving prisons. CRC is currently approved to house 299 CCCMS female mental health

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dormitories might be *"additional"* beds and *not* replacement beds. Using the new dormitories as additional beds would have meant that CRC exceeded AB 900 projections and would have meant 400 new prisoners within a very short time. The health care delivery system at the prison could not withstand such an onslaught. The Receiver's staff raised this urgent issue with State officials and, fortunately, on June 6, 2007 CDCR officials informed the Receiver that the new dorms at CRC will be replacement beds only and not addition housing.

inmates. These CCCMS patients already have been, or soon will be, transferred to CIW, CCWF, or VSPW. However, each of these receiving prisons is already overcrowded with CCCMS patients. As of May 25, 2007, for example, (i) CCWF was operating at 132% of its CCCMS capacity, its Reception Center was operating at 145% of its CCCMS capacity, and its Administrative Segregation Unit housed 24 CCCMS patients; (ii) CIW was operating at 101% of its CCCMS capacity, its Reception Center was operating at 75% of its capacity and its Administrative Segregation Unit housed 89 CCCMS; and, (iii) VSPW was operating at 154% of its CCCMS capacity, its Reception Center was operating at 129% of its CCCMS capacity, its Administrative Segregation Unit held 15 CCCMS inmates and its Security Housing Unit housed another 32. *See* Exh. 4. In light of the existing overcrowding at these facilities, the influx of still more prisoners to these facilities may strain the system to the breaking point.

2. Conversion Of The Sierra Conservation Center ("SCC") Level III facility To A Level III Sensitive Needs Yard ("SNY").

On May 2, 2007, CDCR proposed that SCC be converted from a General Population Level III prison to a Level III SNY. Apparently, the reason for this mission change is the backlog [7] of Level III SNY inmates in reception centers and Administrative Segregation Units.

The Level III facility at SCC is known as "Tuolumne." As of May 16, 2007, it housed -1,192 inmates. Because its design capacity is only 500 inmates, as of May 16, it was at 238.4% of capacity and thus very seriously overcrowded. There were 49 CCCMS inmates housed in the Administrative

Segregation Unit in the Tuolumne facility, as well as an unknown number of general population CCCMS inmates. The tentative start date to begin moving inmates from SCC is June 25, 2007. *See* Exh. 5, p. 5.

The conversion at SCC will require the movement of more than one thousand inmates from SCC and the arrival of more than one thousand inmates into SCC. Each of these 2,000 inmate movements will require Nursing Services to conduct an inmate evaluation or screening. The burden on the health care delivery system will, therefore, be extreme.

It is also important to underscore that the mission changes contemplated at SCC (and elsewhere) have real-life consequences for the affected inmates. The Receiver has received an outpouring of letters from inmates who believe that they have benefited greatly from the rehabilitation programs at SCC and who are now fearful that they will be sent to facilities that lack the same kind and quality of programming. See Exh. 12.

3. Problems With the Delivery of Medical Care in CCFs.

Both AB 900 and the CRC conversion contemplate the placement of additional prisoners into community beds. In anticipation of these changes, the Office of the Receiver has undertaken to investigate the adequacy of medical care at CCFs and has found serious problems.

For example, after receiving telephone complaints about conditions at the McFarland Community Correctional Facility ("MCCF"), the Receiver ordered an unannounced inspection by a team of nurses and a physician. The report from that visit, prepared by Director of Nursing Operations Jackie Clark, raises a number of serious questions about not only patient care, but also fundamental questions of responsibility, authority, policy, and monitoring. See Exh. 6 to Hagar Decl. Just a few of her observations and conclusions are set forth below:

> 1. . . . There are no on-site clinical staff to identify and respond to emergency medical issues from 8:00 p.m. to 8:00 a.m. seven days a week.
>
> [8] * * *
>
> 4. There is no physician backup or oversight for the [nurse practitioner]. This factor and the clinical competency issues of the NP has [sic] resulted in the mismanagement of inmates medical problems.
>
> 5. Record keeping by [the private prison operator] staff is incomplete. There is no tracking system in place to track and follow[] chronic patients. There is no tracking system in place that tracks the inmates being sent out for medical (routine or emergent).
>
> 6. The arrangement with [North Kern State Prison] for emergency transfer of patients after hours is not adequate. There have been unnecessary and dangerous delays concerning the transfer of inmates who required urgent medical care.

Exh. 6, pp. 3-4.

The problems at MCCF are not unique. For example, in April 2007, the Facility Director of the Claremont Custody Center ("CCC") wrote a five-page, single spaced letter to Terry Dickinson, Correctional Administrator-Support Services at CDCR, to voice detailed concerns regarding various medical issues, including: (i) managing an influenza outbreak that spread from inmates to staff; (ii) the "10 inmates per week" limit on referring CCC patients to CDCR for medical or dental needs, regardless of the population at CCC or the seriousness of the medical or dental problem; (iii) the denial of funding to hire needed registered nurses; (iv) the expensive practice of sending CCC inmates to local hospitals via ambulance instead of transferring prisoners to Pleasant Valley State Prison ("PVSP"); (v) the waste of taxpayer funds concerning delayed officer transports; and (vi) the overall scope of practice necessary to deliver adequate care to CCC prisoners. See generally Exh. 7. Indeed, the available evidence indicates that these and other problems in the medical delivery system within the CCC system are of longstanding.[3]

Mr. Dickinson's one-and-a-half page response to the CCC Facility Director's letter is worthy of lengthy quotation for what it reveals about the bureaucracy and inaction characteristic of the CDCR medical delivery system.[4] He writes:

> This is in response to your letter to me dated April 10, 2007, in which you express concerns for medical needs for inmates and staff and request additional Registered Nurses at the Claremont Custody Center (CCC).
>
> [9] . . . As you know, the CCC and all other Community Correctional Facilities (CCF) have limited capabilities regarding medical and dental

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[3] *See, e.g.*, Exh. 9 (E-mail from Assoc. Warden in Nov. 2006, stating that CCC "is no where close to being in compliance with Plata guidelines or timeframes.") *See also* Exhs. 10 and 11.

[4] The Receiver is not criticizing Mr. Dickinson. Instead, the Receiver focuses on the response because it provides a window into the CDCR/State's "trained incapacity."

> treatment for inmates . . . When it is determined . . . that an inmate medical problem exists that cannot be managed in a CCF, the contractor is required to contact the HCM/CMO or Medical Officer of the Day (MOD) at PVSP for direction. The HCM/CMO/MOD will decide the course of medical treatment for the inmate . . . The Community Correctional Facilities Administration (CCFA) cannot determine or authorize the medical/dental treatment of inmates at CCC or any other CCF . . .
>
> The CCFA has submitted the past two years a Budget Concept Statement (BCS) o requesting the Department require 24-hour, Registered Nurse (RN) coverage at each CCF/MCCF. . . . Unfortunately, we have not received funding authority for RN positions.
>
> It is recommended that you directly contact [the HCM or CMO] at PVSP to express your concerns for TB testing, Influenza vaccinations and inmate medical treatment for inmates at CCC. If we receive further information on converting your LVN's to RN's 24 hours a day, we will let you know. . . Thank you for bringing pp your concerns and feel free to contact me if you have any questions . . .

Exh. 8.

The net outcome of this perfectly bland response is that absolutely nothing changes – requests for staffing, improved transportation, improved communication, etc. are at best referred elsewhere and, at worst, ignored altogether. It is also worth noting that none of the documentation reflecting the longstanding problems in the CCFs has been shared with the

Receiver's Office by CDCR. It is quite possible that the private contractors providing services to the CCFs have never even been notified by CDCR that their medical functions were put into receivership more than one year ago.

After an initial review, the Receiver has concluded that significant changes will be needed to bring the delivery of medical care at CCFs up to constitutional standards. Accomplishing this objective will require very basic and far reaching structural changes with respect to how CCFA manages medical problems. At this point, until basic health care services are provided in CCFs, the establishment of yet more CCFs may well jeopardize the medical health of all prisoners assigned to community correctional facilities.

CONCLUSION

As discussed above, from what the Office of the Receiver has learned about the mission changes at CRC and SCC, CDCR's efforts to manage the overcrowding problem (i) has created hundreds of additional "ugly beds" for female prisoners; (ii) will exacerbate existing [10] inadequacies in the health care delivery system, while threatening to cause still others; and, (iii) until basic health care services are brought up to constitutional standards in. CCFs generally, the establishment of still more CCFs in response to overcrowding may jeopardize the health of all prisoners housed in such facilities. Mission changes, yard flips, and prison-to-prison transfers, aggravated by the limited alternatives imposed by overcrowding, are now assuming a size, scope and frequency that will clearly extend the timeframes and costs of the receivership and may render adequate medical care impossible, especially for patients who require longer term chronic care.

Dated: June 11, 2007

FUTTERMAN & DUPREE, LLP

By ____/s/____
Martin H. Dodd
Attorneys for Receiver Robert Sillen

[DEFS053870]

CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

Robert Silien
Receiver

Analysis of CDCR Death Reviews 2006
Public Version

August 20, 2007

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BACKGROUND

The CDCR Death Review Committee (DRC) is a multidisciplinary committee chaired by the Statewide Medical Director and consisting of MDs, RNs, health-care administrators, and correctional officers. The DRC meets 2-4 times monthly to discuss and analyze each death that occurs in the CDCR. Prior to the multidisciplinary reviews, an MD prepares a written report on each death. A subcommittee with representation from mental health, nursing, and custody reviews deaths from suicide. The main DRC reviews all other deaths.

The majority of the year 2006 death review reports were prepared by CDCR QMAT physicians. A minority of the reports were prepared by the Statewide Medical Director, by the Regional CMOs, or by the UCSD contract review physicians.

Each death review report was based on a reading of the patient's available medical record. The reviewer attempted to assess the patient's entire experience with medical care during his/her period of incarceration. The reports focused specifically on the cause of death and the quality of care provided to the patient. Upon identifying significant departures from the community standard of care and potentially problematic providers, the DRC referred cases to the Professional Practice Executive Committee (PPEC) for further evaluation of the provider's fitness for continued service in CDCR. The PPEC interpretation of community standard considers what a reasonable, similarly credentialed provider would do, given the situation in which the care in question was rendered.

The death reviews were valuable in identifying potentially unsafe practitioners. As one step in its practitioner assessments, PPEC conducted pattern of practice reviews for these individuals. Typically, the reviewer assessed a large sample of patient care interactions (usually 40-60 patient charts, including the index death case and any other deaths involving the clinician) for adherence to a community standard of care. After considering evidence from multiple sources, PPEC took one of several actions:

[DEFS053871] 1. Temporary restriction from practice in the CDCR, pending a complete review of the clinician's pattern of practice.

2. A program of remediation, e.g., taking a course in an area of deficiency, followed by close monitoring

3. Suspension of privileges

4. No adverse action.

Sixty-two CDCR practitioners (56 MDs and DOs and 6 Nurse Practitioners) have had adverse action taken by the PPEC, from June 2005 to July 2007. Of these, 41 were initiated by the death reviews.

PURPOSE

Until now, the Death Review Committee and PPEC have been focused on identifying and sanctioning individual practitioners. There has been little or no emphasis on identifying systemic deficiencies of care and acting on them.

The purpose of this analysis is to categorize each of the 2006 deaths as non-preventable, preventable, or possibly preventable, to summarize the major lapses in care (both individual and systemic) contributing to the patient deaths, and to make recommendations for quality improvement.

LIMITATIONS

There were significant limitations in the ability of the reviewers to conduct meaningful death reviews.

A major limitation was the absence of a well-organized, easily navigated medical record. This same limitation plagues the CDCR providers themselves during care provision. The physician portion of the CDCR medical records includes hand-written progress notes suffering from brevity, poorly documented reasoning, and illegible handwriting. The medical records available to reviewers were often incomplete, making it difficult to determine an accurate chronology of events or to "tease out" critical pieces of clinical information. An important laboratory or x-ray result might be misfiled, or the record might be missing recommendations of consultants or records of emergency room visits and hospitalizations.

There was variation in the quality of the death review reports, in part because of the difficulties in the medical record, and in part because there was no template or form for guiding systematic death review. Some reports were quite brief and superficial. Others went into great detail and reflected great effort at reconstructing events and determining clinical reasoning. There was a spectrum of fault finding. Some reports concentrated only on proximate causes of death and did not address the possibility of an early opportunity to make a diagnosis that might have affected a patient's prognosis. Some [DEFS053872] reviewers focused entirely on individual culpability and did not address possible systemic issues of care.

In early 2007 the DRC created a form for reports, leading to greater uniformity. The form prompts reviewers to address nursing issues, systemic issues of care, and preventability of death, in addition to individual practitioner lapses. Only the last 20 of the year 2006 reports used this template.

The majority of deaths did not trigger autopsies. This is usual in the non-CDCR world as well, but it makes complete clinical closure elusive, especially in the cases of sudden cardiac arrest.

There are also inherent limitations in conducting a retrospective, case-based analysis such as this one. There are no established criteria for attribution of "preventability." Research in this area is primarily epidemiological, comparing actual versus expected deaths in large populations over time. A search of the medical literature revealed no case-based studies for preventable deaths in adult primary care. Such studies would be difficult precisely because creating rigorous criteria for preventability would be difficult. Another limitation of this analysis is that it depends wholly on the judgment of a single reviewer. For example, several of the sudden cardiac arrests were judged to be possibly preventable because of a failure of clinicians to evaluate symptoms of syncope or chest pain in the weeks or months prior to the patient's death. Another reviewer might have judged these deaths to have been non-preventable, because there is no assurance that a proper evaluation of these red flag symptoms would in fact have prevented the patients' deaths. Many patients who have complete cardiovascular evaluations, who receive appropriate medications and who have appropriate interventional procedures nevertheless succumb to their disease. And without an autopsy, there is less assurance that the patient had a preventable cardiovascular death. In short, there is no easy methodology that can reliably quantify preventable deaths.

Despite the limitations in the death review process, it has proven useful in identifying many egregious examples of individual errors in judgment and failures to perform commensurate with community standards. This analysis consolidates findings for the year 2006 deaths.

DEFINITIONS

Non-preventable: The health care system and individual providers probably would not have been able to prevent the patient's death. (Homicides and drug overdoses fall here.)

Preventable: Better medical management or a better system of care would have prevented death.

Possibly preventable: Better medical management or a better system of care might have prevented death.

[DEFS053873] FINDINGS

Total year 2006 CDCR deaths	426
Suicides (not included in this analysis)	43

1996

Execution (not included)	1
Death Reviews unavailable for this report	1
Death reviews in this analysis	381
Non-preventable deaths	315
Preventable deaths	18
Possibly preventable deaths	48

A. Non-Preventable Deaths

1. *Causes of non preventable death*

105	Cancer
53	End-stage liver disease
28	Sudden cardiac arrest
17	AIDS
17	Drug overdose
16	Congestive heart failure
16	Homicide
14	Coronary artery disease (likely higher, because over 2/3 of cases of sudden cardiac arrest are attributable in autopsy studies to CAD)
11	COPD
10	End-stage renal disease
7	Stroke
6	Pneumonia
5	Upper GI hemorrhage
5	Coccidioidomycosis
3	Sepsis
2	Pulmonary embolism
4	1 each of diabetic ketoacidosis, neuroleptic malignant syndrome, encephalitis, and subarachnoid hemorrhage
319	Total (Of the 315 cases, several had more than one major cause of death)

[DEFS 053874] 2. *Lapses in care in cases of non preventable* death

Lapses were noted in over half of the cases of non-preventable death. In many cases, these lapses in care may have contributed to an earlier death or more suffering in patients who had fatal diagnoses such as cancer or end stage liver, heart, or kidney disease.

Cases	Lapses
66	Poor primary clinician management – includes instances of clinical inertia in response to abnormal labs or x-rays, not treating to established guidelines and targets (blood pressure, blood sugar, etc), cursory evaluation of signs and symptoms (weight loss, new dementia, syncope, “can’t walk”, new ascites, chest pain, abdominal pain), delayed referral to a higher level of care, illegible handwriting, poor documentation, and fragmented care
15	Poor management of terminal event, including failure to administer narcan
13	System delays – medical records, delayed access to care, delayed response to 602 appeals, delays in obtaining tests, etc
13	Delays in diagnosis
9	Patient “refusal” of care/evaluation
9	Delays in obtaining specialty referral
6	Poor “handoffs” between clinicians, including coordination between inpatient and ambulatory, or at time of inmate transfers
5	Poor palliative care

B. Preventable Deaths

1. *Causes of preventable deaths*

6	Asthma
3	Sudden cardiac arrest
2	Congestive heart failure
1	Acute myocardial infarction
1	Duodenal ulcer, perforated
1	Hyperthermia [redacted]
1	Incarcerated hernia
1	Acute pancreatitis
1	Stroke (probable)
1	Testicular cancer
18	Total

2. *Lapses in care in cases of preventable death*

[DEFS053875] *Asthma* – failure of clinicians to follow published guidelines and standards of care in the evaluation and management of asthma, failure of RNs to appropriately triage sick asthmatics to an MD, failure to ensure timely follow-up after treatment of an acute exacerbation, failure to recognize the volatility of symptoms , failure to refer refractory asthma to a pulmonologist, and a botched handoff in which a steroid dependent asthmatic did not receive steroids for two days following transfer from a county prison to a CDCR facility.

Sudden death – failure by MDs and midlevels to adequately evaluate "red flag" symptoms such as exertional chest pain, chest pain associated with dizziness, and recurrent syncope occurring weeks to months prior to death in patients with cardiac risk factors.

Acute myocardial infarction – failure by MD to come in while on call to evaluate a pt with hypotension and tachycardia, failure to correctly interpret new edema and shortness of breath, and an 8 hour delay in access to MD evaluation while experiencing "constant and extreme" chest pain on the day of death.

Congestive heart failure – midlevel practicing beyond scope of practice in unsupervised or poorly supervised situations, botched handoff from acute hospital to CDCR facility, multiple failed appointments because of dialysis, and MD failure to entertain diagnosis of CHF in a patient with new orthopnea, exertional dyspnea and edema.

Perforated duodenal ulcer – failure by MDs and RNs to adequately respond to patient complaint about severe abdominal pain on multiple occasions over five days, resulting in prolonged delay in diagnosis and treatment.

Hyperthermia – unsafe transfer of [redacted] patient from one CDCR facility to another [redacted] resulting in death from hyperthermia.

Incarcerated hernia – five week delay in referral to specialist for a patient with recurrent severe abdominal pain, vomiting and known bilateral inguinal hernias.

Acute pancreatitis – failure of RNs and MDs to properly triage, evaluate and manage a patient who presented nine times over three days with severe "10/10" abdominal pain, resulting in prolonged delay in recognition and treatment.

Stroke - midlevel practicing beyond scope in poorly supervised setting who failed to evaluate a pt who had symptoms of weakness, inability to walk [redacted] and who was repeatedly known to be "down" for more than 48 hours.

Testicular cancer – two year delay in diagnosis of testicular cancer in [redacted] patient with chronic testicular pain, metastatic at time of eventual diagnosis, botched transfer with inadequate information passed from [DEFS053876] facility to facility (lost urology consult), failure of MDs to work up for cancer in a young man with 17 months of testicular pain.

C. Possibly Preventable Deaths

1. *Causes of possibly preventable deaths*

5	Sudden cardiac arrest
4	Coccidioidomycosis
4	AIDS
3	Acute myocardial infarction
3	Bowel perforation
3	Sepsis
2	Coronary artery disease
2	Congestive heart failure
2	Drug overdose
2	Gastrointestinal hemorrhage
2	Subdural hematoma
2	Colorectal cancer
2.	Opiate toxicity
12	1 each of COPD, gastric cancer, cholecystitis in end-stage liver disease, acute renal failure from rhabdomyolysis following trauma, cervical cancer, lung cancer, pneumonia, aortic dissection, drug induced hepatitis, diabetic ketoacidosis, carcinoma of thymus, seizure disorder
48	Total

2001

2. *Lapses in care in cases of possibly preventable death –*

Cases	Lapses
30	Errors by individual physicians, nursing and midlevel staff – includes failure to adequately evaluate clinical “red flag” signs and symptoms, (chest pain, abdominal pain, weight loss, seizures, altered mental status, fever and tachycardia, poorly resolving pneumonia, joint effusion, history of significant trauma), failure to adequately pursue abnormal test results (leucopenia, abnormal blood sugars, abnormal radiology studies), failure to transfer patients to appropriate higher levels of care, inadequate clinical surveillance of known conditions (cervical cancer, immune compromised patients)
11	Delayed referrals for specialty care or special tests – (cardiology, gastroenterology, vascular surgery, stress tests, etc.)
9	Delays in access (delayed response to patient requests for care – “7362s”)
7	Poor provider communication, including failure to act on specialist [DEFS053877] recommendations and lost medical information when patients undergo interfacility transfers
6	Missed abnormal test results (chest x-rays, CT scan, blood sugars, positive stress tests)
5	Fragmentation of care, multiple providers with no individual ownership of a patient’s complaint or abnormal finding

2002

3	Poor response to emergency or "man down" situations
2	Surgical or procedural complications (colonoscopy and herniorhaphy resulting in perforated bowel)

DISCUSSION

A. Lapses in Care

Significant lapses in care were noted in more than half of the death reviews. These can be divided into individual practitioner lapses, systemic lapses, and "no-fault" lapses

1. *Individual practitioner errors in judgment or attitude*

- Failure to appreciate potentially serious signs and symptoms (exertional chest pain, new onset shortness of breath and dizziness, unexplained tachycardia as harbingers of cardiac events, severe abdominal pain and abdominal distention as signs of acute abdominal catastrophe, increased use of inhalers as prelude to status asthmaticus),
- Failure to tailor the pace of evaluation to the clinical situation (rectal bleeding, testicular pain, indicating rapid workup to detect potentially curable cancers),
- Failure to perform the basic history and physical examination,
- Failure to follow well established guidelines for care (asthma, diabetes mellitus, hypertension, coccidioidomycosis)
- Failure to apply critical thinking or to enlist help in difficult cases

- Superficial or no documentation to indicate thought processes.
- Failure to take individual responsibility for patient outcomes

2. *Systemic lapses*

- A system that allows delays in triaging and processing patient requests for care resulting in patients with red flag symptoms not being evaluated in a timely manner.
- A system that allows fragmentation of care and clinical inertia, leading to lack of individual practitioner responsibility and accountability for each patient.
- Systemic and pervasive prolonged delays in specialty referrals

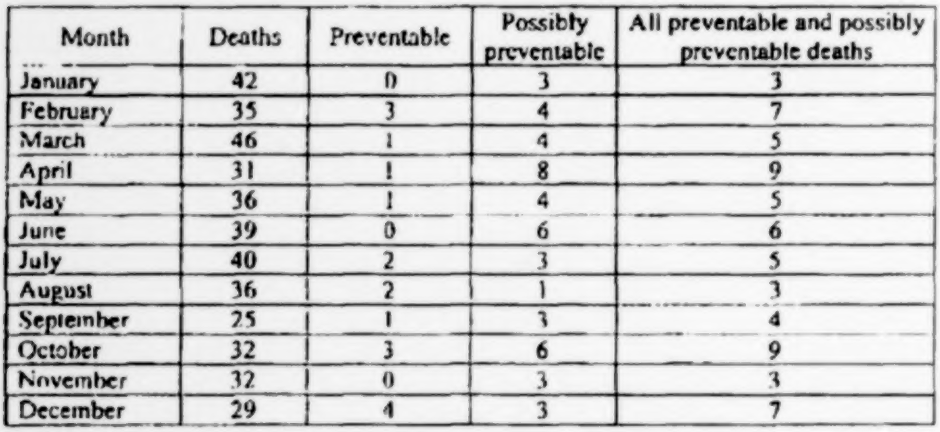
[DEFS053878] – No system for flagging abnormal test results,

- Incomplete medical records
- Poorly managed transfers of care - when patients move from one facility to another, there is increased risk of medical error.
- Practices which place mid level providers in vulnerable clinical situations, poorly supported or unsupported, with little or no mentoring.
- Practice environments (noisy, unkempt, crowded, lacking privacy) and patient characteristics (high rate of dual diagnosis, chronic pain, and manipulation for secondary gain) and other cultural factors which promote practice isolation and discourage collegiality and professionalism.

3. *"No-fault" lapses*
   - Patient "non-adherence" to suggested treatment
   - Patient "refusal" of care or evaluation (sometimes masking frustration with the system of care or reflecting poor provider – patient communication)

B. Trends in Preventable Deaths Over Time

There was no clear trend indicating an increase or decrease in the number of preventable deaths over time. Unlike the situation in hospitals, in which quality improvements can lead to aggregate decreases in mortality within the space of a year, improvements in primary care may take longer before yielding mortality decreases.



Month	Deaths	Preventable	Possibly preventable	All preventable and possibly preventable deaths
January	42	0	3	3
February	35	3	4	7
March	46	1	4	5
April	31	1	8	9
May	36	1	4	5
June	39	0	6	6
July	40	2	3	5
August	36	2	1	3
September	25	1	3	4
October	32	3	6	9
November	32	0	3	3
December	29	4	3	7

[DEFS053879] C. Comment on CDCR Environment of Care

CDCR medical staff has been working in an environment of care characterized by crowded and poorly equipped clinical areas. The medical record systems are outdated and medical information is difficult to retrieve. The dispensing of prescribed drugs is often delayed, and there is an unreliable system for refilling medications for the treatment of chronic medical diseases such as diabetes, hypertension, asthma and coronary heart disease. The drug profile information is unreliable. Practices in many of the prisons focus on episodic care rather than continuity of care and preventive medicine. The environment does not guarantee patient confidentiality, and the culture does not promote patient advocacy.

The patient population has a number of unfavorable characteristics, such as a high incidence of dual diagnosis (serious mental illness coexisting with physical illness), chronic hepatitis, HIV infection, drug and alcohol addiction, and skillful manipulation for secondary gain.

Despite these barriers, it is noteworthy that 167 of the death reports contained no serious lapses in medical care. This is a reassuring indication that there are many conscientious providers and RNs who are doing a good job despite the environment in which they find themselves.

RECOMMENDATIONS

The CDCR must create a culture of patient safety, in which clinicians readily identify mistakes and system vulnerabilities and in which all staff share in the responsibility for optimal patient outcomes. Systems should be reviewed or redesigned to support this end.

To that end, the Death Review Committee should continue in on-going fashion the analyses piloted in this analysis, identifying not only individual performance issues but also the most common systemic lapses in care. The Committee should begin to standardize a list of the lapses and vulnerabilities that contribute to preventable deaths. The Joint

Commission provides examples of how to proceed in this area, e.g., in categorizing the causes of sentinel events or specifically the causes of delays in treatment (see the Sentinel Event Alert of June 17, 2002). The Committee should continue its efforts to standardize its methodology for classifying preventable deaths.

These overall recommendations and most of the specific recommendations which follow are contained in Goals B, C, and D of the California Receiver's Plan of Action of May 2007 (POA). Where applicable, relevant POA goals and objectives follow each numbered recommendation below.

[DEFS053880] 1. Continue PPEC evaluation of individual practitioners referred by the Death Review Committee.

2. Develop and circulate a Clinical Newsletter in order to improve communication, educate CDCR providers about important findings of the Death Reviews and to make meaningful clinical suggestions for improving care. (C.8.1, A.8.5.2)

3. Develop a system wide quality initiative focusing on the management of asthma. (B.2.5, B.2.6.1)

4. Develop system-wide quality initiatives on the recognition and management of "red flag" clinical signs, and other subjects, using death review cases as indicators. (C.1.1, C.1.2, C.6.1)

5. Pilot practitioner "daily reports" at each prison for purposes of peer collaboration and discussion of problem cases, mistakes, "near

misses," cases of patient nonadherence or refusal of care, local system process redesign, development of collegiality, and shared responsibility for patient care. (C.5, C.6, C.8)

6. Redesign CDCR processes for mid-level credentialing, privileging, supervision and mentoring. (A.8.5)
7. Redesign CDCR systems of care (including scheduling) to promote individual and shared responsibility for patient care outcomes, and to reduce fragmentation of care wherever possible. (B.3)
8. Redesign process of RN triaging of form 7362s to eliminate delays in care. (B.7.1, C)
9. Develop systems for tracking and following up abnormal laboratory and other test results. (B.12.1, B.12.2)
10. Create new templates for managing requests for specialty services in order to meet minimum standards for emergency (24 hour) urgent (7-14 day) and routine (60 day) priorities, and to ensure that consultation results are seen by ordering clinicians within one week of service. (B.3.1.8)
11. Review process for response to emergencies. (B.1)
12. Design and implement system-wide integrated health information systems. (goal D)
13. Redesign the environment of care to promote efficiency, teamwork, professionalism, and respect for patients, creating an ethically-based system of care. (B.3, B.10)

14. Wherever applicable, develop the standard quality metrics to support the foregoing recommendations. (POA, page 47)

[DEFS059781] COMPILATION OF SUMMARIES AND RECOMMENDATIONS FROM SPECIAL MASTER'S MONITORING REPORTS IN *COLEMAN v. SCHWARZENEGGER*

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[DEFS060220] SUMMARIES AND RECOMMENDATIONS FROM SPECIAL MASTER'S FIFTEENTH MONITORING REPORT IN *COLEMAN v. SCHWARZENEGGER*

* * * *

[DEFS060272] The problem of inadequate MHCBs, in all likelihood, will endure until at least mid-2008. A 12-bed MHCB unit is due to be activated imminently in the newly opened Kern Valley State Prison, and the construction of another unit of 12 beds is scheduled to be completed at CSP/Sac in December 2005. lithe defendants were able to get its full current complement of 177 MHCBs (182 less the non-existent five at CEN) for males actually up and running, add these 24 new beds, get ASH to accept the 25 MHCB referrals they are being paid to treat, and continue to place 15 to 20 CMP inmates in need of a MHCB level of care in DMH/APP, they just might be able to bridge the gap to the 2008 completion of the 50-bed MHCB unit at CMF. Fulfillment of all of these conditions, however, will require urgent, effective and coordinated action on the pan of CDCR, DMH and DHS. Moreover, updated and more accurate population plans and projections will need to be developed to determine whether the addition of 50 additional MHCBs in 2008 will suffice to meet the then-existing need, given the surging overall CDCR population.

PSUs: During the monitoring period, the list of inmates referred to a PSU but awaiting transfer also continued to climb, reaching 43 in early May. For some time, the defendants have assured the monitor and the court that a 64-bed PSU at CSP/Sac was under construction and would be ready for initial occupancy by March 2006. It is important that the projected timeline be met.

Reception EOP and 3CMS Transfers:

Whatever progress was reported in the preceding round of review, or in the early pan of the current review, in the timeless of transfers of MHSDS inmates out of reception into general population programs has been largely cancelled by the recently [DEFS060273] escalating growth in the overall CDCR population and the concomitantly increasing number of MHSDS inmates in reception. For example, in August 2003, the five major reception centers of CM, DVI, MOP, SQ and WSP housed a total of roughly 3,018 EOP and 3CMS inmates awaiting transfer or parole. By August 2005 that number rose to 3,988, an increase just short of a full third. The growth reflects several factors including, perhaps most importantly, the surge in CDCR's overall population and the untimely expansion of the capacity of general population MHSDS programs to meet actual program needs. Staffing for mental health programs increases only on a post facto basis, i.e., after CDCR reports to the Department of Finance (DOF) twice annually the actual growth of the MHSDS population by program. DOF then includes a request for expanded MHSDS staffing in the upcoming annual or supplemental budget proposal. To report the requisite population growth, seek and obtain funding for expanding program staff and actually obtaining the bodies to fill newly allocated positions generally takes eight to ten months. Thus, as long as the MHSDS caseload remains in a state of growth, program capacity in terms of staffing will continue to trail actual program population. Meanwhile, just because staffing is allocated does not mean physical space exists in the system for housing expanded MHDS programs, so further delays often occur.

It is difficult to see how the defendants can escape from this bureaucratic box. One response, and one included in the revised program guides, which are wending their way toward judicial approval, is to increase mental health staff in reception centers to enable the Provision of adequate interim monitoring and treatment for EOP and 3CMS inmates stuck overlong in reception. For the moment, pushing the program guide.

* * * *

[DEFS060297] The monitor's most recent reports have focused steadily and largely on this relatively small portion of the MJISDS caseload population most in need of intense mental health treatment and heightened security. And over the past (locale, the defendants have gradually developed programs to address the treatment needs of this core of seriously mentally disordered inmates at the apex of the MHSDS pyramid of treatment and security, including programs for Level IV EOP inmates in need of protective custody on a Special Needs Yard, EOP inmates in administrative segregation, PAP inmates with a SITU term (PSUs), inmates in need of a MHCB level of care and Level IV inmates with a history of violence in need of intermediate inpatient DMH cam.

The problem is that the availability of such programs has not kept pace with the expansion of the

MHSDS or the overall CDCR populations, and over the past decade, the population of the former has risen proportionally much faster and higher than the latter. In addition, the recently completed Unidentified Needs Assessment indicated that, in the absence of available beds, institutional clinicians were not referring numerous inmates actually in need of inpatient DWI mental health care, resulting in an instant expansion in the demand for inpatient Mill programs. Thus, CDCR now needs more MHCBs and PSU beds and lots more Level IV inpatient DMH beds than it currently possesses. Currently long waiting lists for these beds mean that suicidal and other seriously mentally ill and violent inmates lack access to clinically necessary levels of monitoring and treatment. Some plans for further expansion of these programs have been developed in response to court orders, but they proceed fitfully and awkwardly, beset by bureaucratic obstacles that threaten to delay their realization for years. Other plans lack essential legislative funding, without which they cannot advance it is time for the [DEFS 060298] defendants, not just CDCR, to finalize and expedite existing, disparate and uncoordinated plans to expand the capacity of MHSDS programs the most seriously mentally ill core population.

The defendants' recent history of developing erratic plants or plans they are unable subsequently to implement suggests the present need for something more than just another requirement for the gateman of yet snort plans. Whatever the formal response of the panics to the recommendations in this final version of the 15th report on compliance, the monitor respectfully requests the court to hold a hearing to ensure that the defendants understand precisely what burdens they will be expected to bear in response to whatever proposed recommendations are incorporated in the court's final order, or in the alternative, schedule a hearing for the end of April 2006 to assess the adequacy of the plans presented by the defendants in response lathe court's directives.

Respectfully submitted

/s/ J. Michael Keating, Jr.
J. Michael Keating, Jr.
Special Master

January 13, 2006

[DEFS 060299] SUMMARIES AND RECOMMENDATIONS FROM SPECIAL MASTER'S SIXTEENTH MONITORING REPORT IN *COLEMAN v. SCHWARZENEGGER*

[DEFS060300] IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA

CIV No. 5-90-0520 LICK JFM P

RALPH COLEMAN *et al.*
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

SIXTEENTH MONITORING REPORT OF THE SPECIAL MASTER ON THE DEFENDANTS' COMPLIANCE WITH PROVISIONALLY APPROVED PLANS POLICIES AND PROTOCOLS

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December 13, 2006

* * * *

[DEFS060302] conducted simultaneously, which had not occurred so far. Other institutions using video monitoring adequately included CGI, CIW and RD.

Suicide watches at SQ were conducted exclusively by video monitoring with five camera watch rooms in use and monitors in the officers' station. Two months before the monitor's visit, six cells with video cameras and a monitor in an additional officers' station were added. However, use of video monitoring at SQ was confusing and difficult to assess. Not surprisingly, one of the two horrific cases involving the use of video monitoring that led to the moratorium occurred at SQ.

Video monitoring at CIW and CCWF led to concerns about inordinate and sometimes inappropriate use and gender-related privacy problems.

Overall, the use of video monitoring was plagued by serious technical deficiencies and inadequate training and supervision locally, and an utter lack of any centralized direction, oversight or coordination. The moratorium was well-advised, and the department would do well to abandon permanently reliance on video monitoring to replace one-on-one personal observation of suicidal inmates. Examination and planning apparently were aimed, commendably, at reducing the cost of one-on-one observation by substituting trained mental health/medical nursing aides for high-priced correctional officers. The goal is constant observation and some modicum of interpersonal connection with the inmate(s) under surveillance.

Conclusion and Recommendations

The 166 monitoring round began in the summer of 2005, but was not physically completed until March 2006. The compilation and production of this report has been punctuated and delayed by a series of intervening events, including the approval [DEFS060303] in early 2006 of the bulk of the revised Program Guide and the ensuing struggle to secure adequate staffing to implement it; a series of hearings and reports on the defendants' plans for assessing and meeting the need for intensive treatment and high custody beds; a special session of the Legislature supposedly focused on CDCR's growing problems; and the initiation of the Plata receivership. All of these events, occurring against a backdrop of a steadily escalating overall prison population serious enough to impel the Governor most recently to declare a state of emergency, have contributed substantially to a long overdue report, a problem that will be addressed below. In the meantime, many of the critical issues raised in this report have already been defined in one or another of these competing forums, and the search for effective responses is already underway.

The single most serious problem chronicled in this report is the continuing deterioration of mental health staffing. The obvious cause of the problem is the inexorably expanding demand for services resulting from the bulging population. By early spring, CDCR's total institutional population topped 110,000. As of mid-April, the mental health caseload stood at 32, 212 inmates, 14.2 percent over existing program capacity. At the same time, 38.49 percent of the department's allocated psychiatrist positions were vacant, as were 24.96 percent of allocated psychologist and 25.8 percent of allocated psych social worker positions. Efforts to obtain the contracted services of temporary clinicians, moreover, also deteriorated due both to bureaucratic difficulties and a long-standing inability of the defendants to pay millions of dollars worth of pending contractor bills. By May 2006, the patient work of a decade, which saw the functional vacancy rate among psychiatrists in 2002 shrink to some five percent and among caseworkers to some two percent, was simply swept away. Even after contracting, [DEFS060304] clinical resources were 12 to 15 percent shy of existing program capacity, while the actual population exceeded program capacity by another 14 percent. Twelve years after the determination that mental health treatment in CDCR was unconstitutional, the defendants still lacked clinical resources to meet the needs of some 25 to 30 percent of inmates identified as seriously mentally disordered.

The defendants' scrambling efforts to calculate their need for intensive care units accurately and develop plans to meet the identified need have occupied much of the past two years. The resulting long term and interim plans are ambitious but still not final; they include substantial increases in inpatient DWI beds and MHCB units, as well as a considerable expansion of EOP beds. Meanwhile, clinical staffing allocated over the past few months to implement the interim programs, keep up with the growing population and meet the requirements of the revised Program Guide amounts to nearly a third of the already existing mental health staff. The resulting infusion of staff, clearly needed to meet the growing demand for services, exceeds considerably the size of the total mental health staff when the original remedial order was entered in *Coleman*.

The real difficulty, however, lies in the recruitment of clinicians to fill these allocations; without incumbents, the allocated positions are largely useless. The defendants have promised regularly for over a decade to reform and regenerate their recruitment efforts without effect. The administration of recruitment has been centralized and decentralized; the list of advertisements and "recruitment events" has steadily expanded; creative alternatives, including internships, educational loan repayment programs, etc. have been initiated with meager results. Meanwhile, the compensation of some categories of CDCR mental health clinicians has slipped further and further behind [DEFS060305] comparable levels of pay in both public and private sectors. The Department of Personnel Administration's most recent survey of comparable pay rates confirmed the substantial inequities reported anecdotally for CDCR staff psychiatrists, clinical psychologists and recreational therapists and to a lesser extent for psych social workers. To date, these findings have resulted in no proposals for pay increases to address these inequities. Whatever increases have occurred over the past ten years have come in the form of court orders or incremental bumps in differential recruitment and retention (R&R) rates for some positions in some institutions where recruitment was especially difficult, The major effect of these increases has been to sow uncertainty, chaos and increasing disparity in payment scales, while doing little to reduce the inequitable compensation paid to psychiatrists, psychologists, psych social workers and recreational therapists in CDCR.

In 2005, DMH began to recruit staff for its new Coalinga State Hospital (CSH), adjacent to CDCR's PVSP and close to ASP. While DMH had limited success in recruiting staff for its remote Coalinga site among clinicians in the general community, it was able to offer better salaries and higher entry level payments than the neighboring CDCR facilities were paying their clinicians. The new CSH facility, moreover, is a state-of-the-art structure; caseloads are significantly lighter than those in CDCR; overtime requirements are minimal; the primary function of CSH is mental health, not security. Not surprisingly, some mental health staff at PVSP and ASP opted to seek employment in CSH. Not one of the 63 allocated psychiatrist positions at PVSP and ASP had a permanent incumbent.

[DEFS060306] The receiver in *Plata* has now sought a waiver of applicable state laws from the court to implement substantial across-the-board pay increases, comparable with compensation in the private sector, for medical staff in CDCR. Why would any mental health RN in CDCR elect to continue working in the same facility with the same conditions of work for substantially less pay than her or his colleague on the medical staff? Why would any RN from the general community choose to work in mental health in a CDCR institution at a level of compensation significantly lower than that provided for RNs on the medical side of the house? The implementation of the new pay scale for medical staff without a comparable increase for mental health staff would deal a further crippling blow to the delivery of mental health services.

The general breakdown in transfers was another transcendent issue in the 16th round of review. As the overall caseload population continued to increase, so too did the percentage of the caseload in need of program beds with intensive care and high security, including specifically DMH inpatient beds, MHCBs, PSU beds and EOP administrative segregation placements. During the monitoring period, the inadequacy of MHCBs led to the particularly worrisome utilization of inappropriate and dangerous alternative placements in everything from so-called "ZZ" or contraband cells to metal holding cells or "cages" in open corridors, where neither monitoring nor treatment was regularly provided. To eliminate these inadequate alternatives, the defendants elected instead to create "Mental. Health OHUs" in a number of institutions, some with and some without MHCB units. This response followed a decade-long effort to wean institutions without MHCB units from reliance on understaffed and physically inadequate OHUs to observe and treat suicidal inmates and rigidly compel the transfer of such inmates within [DEFS060307] 72 hours. This new emergency strategy has the potential for reviving and institutionalizing a bankrupt concept. Only recently and belatedly have the defendants begun to address the policy and staffing implications of this crisis strategy.

The 15th round monitoring report, which described the growing crisis in the shortage of beds in intensive care programs for high custody inmates, resulted in recommendations and orders in early March 2006 that led to a series of court hearings, orders and reports designed to deal with the issue in both the short and long term. Meanwhile, as demonstrated in this report, access to appropriate levels of care for seriously mentally ill inmates remained a problem in almost every CDCR institution.

With regard to medication management, the *Plata* receiver commissioned a contract to review CDCR practices in the management and administration of medications. The contractor confirmed the inefficiency and inadequacy of the department's pharmaceutical-practices. The *Plata* court subsequently endorsed the finding, and the receiver has issued a RFP to take over and operate the department's pharmacy operations and management. This development will eventually shift to *Plata* responsibility for many of the medication-related issues that have occupied *Coleman* monitoring teams, including the use and maintenance of MARS, the acquisition of medication consent forms, continuity of medications, the administration of HS medications, laboratory testing and the distribution of parole medications. Some medication-related issues will need continuing *Coleman* involvement, including Keyhea orders, the DOT administration of medications and medication non-compliance. These latter issues will involve ongoing active *Coleman* monitoring, but even the former issues will need input from mental health to ensure that policies and protocols involving

* * * *

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
September 2, 2008

WEEKLY REPORT OF POPULATION
AS OF MIDNIGHT August 27, 2008

	TOTAL CDCR POPULATION							
				CHANGE SINCE 08/29/07				
	FELON/ OTHER	CIVIL ADDICT	TOTAL	NO.	PCT.	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
A. TOTAL INSTITUTIONS	171,204	853	172,057	-1,099	-0.6			
I. IN-STATE	166,416	853	167,269	-5,887	-3.3			
(MEN, Subtotal)	155,041	624	155,665	-4,886	-3.0			
(WOMEN, Subtotal)	11,375	229	11,604	-140	-1.1			
1. INSTITUTIONS/CAMPS	159,893	845	160,738	-4,999	-3.0	84,066	191.2	162,395
INSTITUTIONS	155,507	845	156,352	-4,940	-3.0	79,828	195.9	158,036
CAMPS(CCC & SCC)	4,386		4,386	-59	-1.3	4,238	103.5	4,359
2. COMMUNITY CORR. CTRS.	6,305	7	6,312	-92	-1.4	5,969	105.7	
CCF PRIVATE	2,920	1	2,921	+16	+0.5	2,752	106.1	
CCF PUBLIC	2,733		2,733	-7	-0.2	2,461	111.1	
DRUG TREATMT FURLOUGH	369	6	375	-97	-20.5	440	85.2	
PRIVATE WORK FURLOUGH	72		72	-21	-22.5	110	65.5	
PRISONER MOTHER PGM	72		72	+1	+1.4	70	102.9	
FAMILY FOUNDATION PGM	73		73	+10	+15.9	70	104.3	
WORK FUR. IN CUSTODY	66		66	+6	+10.0	66	100.0	
3. DMH STATE HOSPITALS	218	1	219	+65	+42.3			
II. OUT OF STATE(COCF)	4,788	0	4,788					
ARIZONA	2,078		2,078					
MISSISSIPPI	1,618		1,618					
OKLAHOMA	1,019		1,019					
TENNESSEE	73		73					
B. PAROLE	122,615	1,471	124,086	-3,831	-2.9			
COMMUNITY SUPERVISION	121,201	1,471	122,672	-3,749	-2.9			
COOPERATIVE CASES	1,414		1,414	-82	-5.4			
C. NON-CDC JURISDICTION	1,824	0	1,824	-105	-5.4			
OTHER STATE/FED. INST.	514		514	+10	+1.9			
OUT OF STATE PAROLE	1,133		1,133	-121	-9.6			
OUT OF STATE PAL	61		61	-17	-21.7			
CYA-W&IC 1731.5(c) INSTITUTIONS	116		116	+23	+24.7			
D. OTHER POPULATIONS	19,907	162	20,069	-500	-2.4			
INMATES								
OUT-TO-COURT, etc	2,286	51	2,337	+48	+2.0			
ESCAPED	225		225	+6	+2.7			
PAROLEES (PAL/RAL)	17,396	111	17,507	-554	-3.0			
TOTAL CDCR POPULATION	315,550	2,486	318,036	-4,674	-1.4			

CHANGE FROM LAST WEEK			
A. TOTAL INSTITUTIONS	+126	-7	+119
(MEN, Subtotal)	+41	-6	+35
(WOMEN, Subtotal)	-6	-1	-7
B. PAROLE	-383	-7	-390
D. PAROLEES (PAL/RAL)	+133	0	+133

This report contains the latest available reliable population figures from OBIS. They have been carefully audited, but are preliminary, and therefore subject to revision.

Figure excludes institution based camps. Total persons in camps, including base camps, are 4,410. Base camp at CMC is included in institution counts.
Report # TPOP-1W. Questions: (916) 327-3282 (CALNET) 467-3282.

BEST AVAILABLE COPY

[1] Analysis of Year 2007 Death Reviews

November 3, 2008

Kent Imai, MD
California Prison Receivership

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[3] I. Introduction

The mortality rate per 100,000 California prison inmates has decreased from 248.6 in 2006 to 230.3 in 2007 to 218.2 in January-June 2008. The decrease is even more impressive when taking normal seasonal variation into account. The January-June rates were 270.5 in 2006, 245.4 in 2007, and 218.2 in 2008. The number of clearly preventable deaths has also decreased.

The major clinical impact felt throughout the system since the beginning of the Receivership has been from improvements in the number and caliber of healthcare professionals. About half of the primary care physicians and over a third of the nurses working for California Prison Health Care Services (CPHCS) have been recently recruited. Most of the Receiver's other interventions that aim to improve the quality and cost-effectiveness of healthcare services are still in early, pilot, or planning stages.

The year 2007 death reviews also revealed at least 292 extreme departures from the standard of care. Refinements to the death review process focused on classifying these standard-of-care departures into a taxonomy of 14 lapses in care. Use of the taxonomy has begun to inform responses to individual provider error as well as systemic improvement strategies. This report concludes with interventions that could mitigate each of these 14 lapses in care.

II. Death Review Process

Clinician members of the Clinical Support Unit (CSU), all of whom have been trained in the process of death review, prepare initial Death Review Summaries of each death in the California Department of Corrections and Rehabilitation (CDCR). CSU physicians are all either board-certified in internal medicine or family medicine. Mid-level reviewers (nurse practitioners or physician assistants) also participate; their reviews are closely examined and approved by one of the physician members of the unit.

Each Death Review Summary is based on a reading of the patient's available CDCR medical record, which may include discharge summaries, specialist reports, and other documentation generated outside the institution. Using a standardized template, the reviewer assesses the patient's last 12 months of medical care during his/her period of incarceration. (For suicides, the reviewer assesses the entire patient record.) The purposes of this extensive review of each inmate's death are to:

- Determine the cause of death, using autopsy findings when available;
- Determine the preventability or non-preventability of the death;
- Identify significant departures from the community standard of care attributed to an individual provider;
- Identify significant health care system lapses in care; and
- Refer for appropriate action, situations in which individual or systemic lapses are noted.

[4] Every completed Death Review Summary is presented by the reviewing clinician to the Death Review Committee (DRC), a multidisciplinary group chaired by one of the three Regional Medical Directors. The DRC is multidisciplinary. Members of the DRC are the Statewide MediCal Director, the three

Regional Medical Directors, the three Regional Directors of Nursing, the Chief Medical Officers of the Clinical Support Unit, other healthcare administrators, nursing consultants and correctional officers.

The DRC may make referrals to several areas. For facility systemic lapses, referral is usually made to the local healthcare manager. For nursing lapses, referral is made to the Department of Nursing. In the case of individual provider lapses occurring while the patient is an outpatient, the case may be referred to the CPHCS Peer Review Subcommittee or directly to the Professional Practices Executive Committee (PPEC), the parent peer review committee for CPHCS. Non-CPHCS specialty consultants are notified of adverse peer review findings or asked to explain their decision-making. Occasionally another specialist may be asked to review the care provided. For lapses in care occurring in community hospital settings, cases may be referred to the Chief of Staff of the hospital in question for consideration within their internal peer review process.

Since the creation of the Receivership in 2005, the death review process has focused on identifying and sanctioning unsafe individual practitioners. Through July 2008, PPEC has taken adverse action on a total of 85 practitioners. The majority of these actions were initiated by a death review.

The Receiver has also increased salaries and diligently recruited new healthcare professionals. CPHCS hired 172 new primary care physicians between August 1, 2007 and July 31, 2008; all are board-certified in internal medicine or family medicine as required by the new credentialing criteria. This figure represents 47 percent of the 366 authorized positions in the physician pool. During this same period (August 1, 2007 through July 31, 2008), CPHCS added 488 registered nurses and 533 licensed vocational nurses to the prison healthcare delivery system. Of the total pool of authorized nursing classifications, 35% were hired during this 12-month period.

When the Death Review Committee refers an individual provider to PPEC in response to, practice concerns, PPEC may choose to conduct a pattern of practice (POP) review to evaluate the performance of the provider. This POP review is a detailed assessment using a large sample of patients and health care interactions (usually 30-50 patient charts, including the index death case and any other deaths in which the clinician may have been involved). The POP review evaluates adherence to a community standard of care. After considering evidence from this and other sources (such as the Chief Medical Officer, Chief Physician and Surgeon, and the provider), PPEC will take one of several actions, including, but not limited to:

1. Summary suspension of some or all clinical privileges;
2. Temporary restriction of practice, pending an even more complete review of the clinician's pattern of care;
3. A program of remediation (for example, taking a course in an area of clinical deficiency, followed by a period of monitoring); or
4. No further action.

[5] Beginning in late 2006, each death was assessed for three levels of preventability: possibly preventable, preventable, or non-preventable. The

death review template was revised to direct reviewers to assess and assign preventability whenever possible. The "Analysis of CDCR Death Reviews 2006," with assessment of preventability now available, offered a number of recommendations to reduce preventable deaths.

The death review process is also intended to identify significant lapses in the processes of care occurring in each death. Significant lapses in care have been identified in all types of deaths, whether preventable or non-preventable. In late 2007, a taxonomy was developed for these lapses (or departures from the standard of care), so that reviewers might be able to use a common "language" when discussing preventable deaths and develop plans of action designed to mitigate such lapses in care. Beginning in 2008, this taxonomy for lapses in care was incorporated into the Death Review Template. The Receiver and CPHCS leadership have begun to use the taxonomy to systematically address the deficiencies in care, with the ultimate goal of reducing the burden of preventable deaths and unnecessary suffering.

Also in 2008, the death review process began to incorporate the principles of "just culture." Just culture assessments distinguish "knowing violations" from three classes of human fallibility: human error (inadvertent), at-risk conduct (taking shortcuts leading to increased risk), and reckless conduct (choosing to put someone in harm's way). The overarching recommendation from last year's deaths analysis remains compelling: "The CDCR must create a culture of patient safety in which clinicians readily identify mistakes and system vulnerabilities and in which all staff share in the responsibility for optimal patient outcomes."[1]

A. Definitions

Non-preventable: In the judgment of the reviewer, the medical health care system and individual practitioners probably would not have been able to prevent the patient's death. (The majority of "natural - expected" deaths fall in this category. Most homicides, suicides, and drug overdoses, although theoretically preventable, are, for purposes of this analysis, placed, in the "non-preventable" category).

Preventable: In the judgment of the reviewer, better medical management or a better system of care would likely have prevented the patient's death.

Possibly preventable: In the judgment of the reviewer, better medical management or a better system of care may have prevented the patient's death.

Extreme departure from the standard of care: A lapse in care that a reasonable and competent clinician would not render under the same or similar circumstances.

Simple departure from the standard of care: A lapse in care that a reasonable and competent clinician might render under the same or similar circumstances

[6] B. Taxonomy for Lapses in Care

The Death Review Committee assigns extreme departures from the community standard to one of the following 14 lapses in care:

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[1] Imai K. Analysis of CDCR Death Reviews 2006. August 20, 2007. Found at: www.cphmca.govfresource.aspx

1. *Failure to recognize important symptoms/ signs.* Failure to recognize, evaluate and treat clinical "red flags." Examples include acute chest pain in high risk patients, shortness of breath, abdominal pain, dizziness, abnormalities of vital signs, low oxygen saturation, acute confusion, weight loss, and increased frequency of medication use.

2. *Failure to follow clinical guidelines.* Failure to follow established guidelines for the screening, evaluation, monitoring and/or management of specific conditions, such as asthma, hepatitis C, diabetes, and chronic pain.

3. *Delay in access to care. Delays in access to care of sufficient duration to result in harm to the patient.* These may occur in any of the following areas or functions: triage, same day, primary care clinic, chronic care or specialty care/procedure.

4. *Failure to identify/follow-up abnormal test results.*

5. *Failure of appropriate provider-to-provider communication*, including specialty consultation, patient transfers between different levels or sites of care and other handoffs including shift changes.

6. *Fragmentation of care.* Episodic care provided in the absence of a primary care system; important elements of the patient's clinical picture are missed and the individual provider does not take responsibility for the patient's outcome.

7. *Surgical or procedural complications resulting in iatrogenic injury.*
8. *Medication prescribing error.* This includes failure to prescribe the indicated medication for a clinical condition, to do appropriate monitoring, or to recognize drug interactions.
9. *Medication delivery error.* Delays in patients receiving critical medications, or patients receiving the wrong medication.
10. *Practicing outside the scope of one's professional competence.*
11. *Failure to supervise mid-level (nurse practitioner or physician assistant) care.* This includes failure of assigned supervisors/mentors to be readily available, as well as managerial failure to arrange appropriate supervision.
12. *Failure to communicate effectively with the patient.*
13. *Patient non-adherence with suggestions for optimal care.*
14. *Delay/failure in emergency response.* Includes failure to follow emergency response protocol as well as delays in activation.

C. Limitations of the Death Review Process

Reviewers face significant limitations on their ability to conduct high quality death reviews, including:

[7] *Medical record.* CPHCS does not have electronic medical records. The typical patient health record is not easily navigated and not well organized. The physician portion of the record includes handwritten

progress notes that may suffer from brevity, poorly documented reasoning and illegible handwriting. The health record is often incomplete, missing critical recommendations from consultants or records of off-campus procedures, emergency room visits and hospitalizations. These challenges plague CPHCS health care providers during the process of care.

Autopsies. The majority of deaths, as in the non-CPHCS world, do not trigger autopsies. This makes clinical closure elusive, especially in cases of sudden cardiac arrest. Nevertheless, knowledge of the cause of death should not alter recognition of and response to serious lapses in care. Furthermore, autopsies may only help to determine whether that lapse led to an adverse outcome.

Preventability. As discussed in last year's deaths analysis, there are limitations in attributing preventability. In one published study, for example, investigators in the Veteran's Administration had fourteen board certified internal medicine specialists, trained in implicit chart review, analyze 383 hospital deaths. In this study, 88 or 23% of the deaths were rated as possibly preventable by optimal care, and another 23 or 6% were rated as preventable. Inter-rater reliability for these ratings, however, was quite low at 0.34. The authors of the study noted that, to a large extent, "preventability is in the eye of the beholder."[2]

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[2] Hayward RA, Hofer TP. Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer. JAMA. 2001, 286; 4, 415.

D. Impact of Preventability

In this 2007 deaths analysis, there was no attempt to estimate the impact of preventability in terms of life expectancy. The preventable death of a young asthmatic, for example, may be more consequential in terms of years of life lost than the preventable death of an 80-year-old patient with multiple chronic illnesses.

In mid-2008, the death review committee began asking reviewers to answer three additional questions intended to add nuance to their judgments.

1. How likely was it that the patient's death could have been prevented or delayed by more optimal health care?
2. How likely was it that the patient's death was caused by or hastened by health care interventions?
3. How much longer would the patient likely have lived if the death had been prevented or delayed?

[8] III. Findings

A. Preventability

In 2007 there were 397 California inmate deaths. For purposes of this report, two reviews were unavailable, leaving 395 subject to analysis here. The majority of deaths, 83 percent (327 cases) were identified as non-preventable (Figure 1). Table 1 shows preventability by the type of death.

Figure 1. California inmate deaths, 2007

Figure I. California inmate deaths, 2007

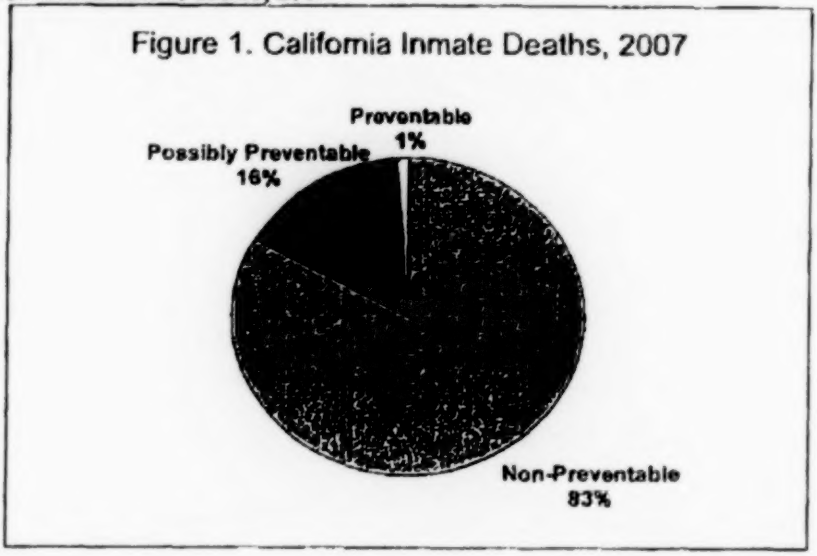
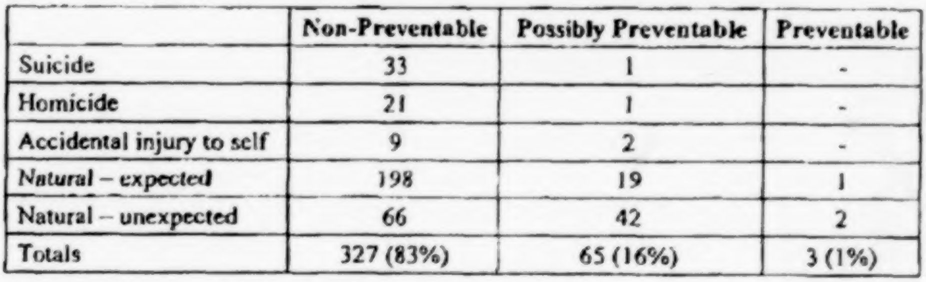


Table 1. Type of death and preventability.



	Non-Preventable	Possibly Preventable	Preventable
Suicide	33	1	-
Homicide	21	1	-
Accidental injury to self	9	2	-
Natural – expected	198	19	1
Natural – unexpected	66	42	2
Totals	327 (83%)	65 (16%)	3 (1%)

[9] B. Non-Preventable Deaths

Table 2 shows the causes of non-preventable death among California inmates in 2007. Cancer and end stage liver disease (all but a few secondary to chronic hepatitis C) together were responsible for 158 (48 percent) of the 327 cases.

Table 2. Causes of non-preventable death.

Cases	Cause of Death
104	cancer
54	end stage liver disease
33	suicide
22	sudden cardiac arrest
22	homicide
12	AIDS
9	stroke
9	drug overdose
7	pneumonia
7	acute myocardial infarction
7	congestive heart failure
5	end stage renal disease
3 each	coccidioidomycosis (valley fever), chronic obstructive pulmonary disease , dementia; pulmonary fibrosis
2 each	bowel infarction, cardiomyopathy, endocarditis, Parkinson disease, sepsis, urosepsis
1 each	amyotrophic lateral sclerosis, aortic aneurysm, coronary artery disease, cerebellar degeneration, pancreatitis, pulmonary embolism, systemic lupus erythematosis, subdural hematoma
4	unable to be determined
327	Total

Table 3 shows the number of extreme-departure lapses in care for non-preventable deaths using the 14-lapse taxonomy. In 161 (49 percent) of these 327 non-preventable deaths, no serious departures in care were noted. Many of these cases were cited for excellent and compassionate care. In the remaining 166 deaths, however, there were 172 lapses identified. Note that 1) a patient could suffer from more than one type of lapse and 2) if a specific type of lapse occurred more than once for a patient, it was counted only once.

[10] Table 3. Types of lapses in care (extreme departures) for non-preventable deaths.

Lapses	Types of Lapses in Care (Extreme Departures)
52	#1 - Failure to recognize, identify or adequately evaluate important symptoms or signs
19	#2 - Failure to follow established guidelines for evaluation and/or management of specific condition
31	#3 - Delay in access to care sufficient to result in harm to the patient
13	#4 - Failure to adequately pursue abnormal test results
4	#5 - Failure of provider-to-provider communications including botched handoffs
10	#6 - Fragmentation of care such that individual responsibility for patient is waived
1	#7 - Surgical/procedural complication resulting in iatrogenic injury

14	#8 - Medication prescribing error
5	#9 - Medication delivery error
4	#10 - Practicing outside the scope of one's capabilities
6	#11 - Unsupervised mid-level (nurse practitioner or physician assistant) care
0	#12 - Failure of communication with patient
5	#13 - Patient non-adherence with recommendations for care
3	#14 - Delay in emergency response or failed to follow emergency response protocol
5	Other (including unavailability of medical record)
172	Total number of extreme departure lapses (many cases had more than one extreme departure)

C. Possibly Preventable Deaths

In 2007, 65 deaths were identified as possibly preventable. Table 4 shows the causes of death and Table 5 shows the lapses in care noted in these 65 cases.

[11]Table 4. Causes of possibly preventable deaths.

Cases	Cause of Death
14	sudden cardiac arrest
7	cancer
6	end-stage liver disease
5	stroke

3	each pulmonary embolism, sepsis
2 each	AIDS, aneurysm (aortic), congestive heart failure , coccidioidomycosis, pneumonia, suicide
1 each	acute myocardial infarction , bowel perforation, coronary artery disease (CAD), cardiomyopathy, colitis, chronic obstructive pulmonary disease (COPD), diabetic ketoacidosis , drug overdose, ependymoma, homicide, metabolic acidosis, spinal stenosis, ulcer, urosepsis, volvulus
65	Total

[12] Table 5. Types of lapses in care (extreme departures) for possibly preventable deaths.

Lapses	Types of Lapses in Care (Extreme Departures)
43	#1 - Failure to recognize, identify or adequately evaluate important symptoms or signs
6	#2 - Failure to follow established guidelines for evaluation and/or management of specific condition
20	#3 - Delay in access to care sufficient to result in harm to the patient
5	#4 - Failure to adequately pursue abnormal test results
5	#5 - Failure of provider-to-provider communications including botched handoffs
7	#6 - Fragmentation of care such that individual responsibility for patient is waived

3	#7 - Surgical/procedural complication resulting in iatrogenic injury
7	#8 - Medication prescribing error
3	#9 - Medication delivery error
1	#10 - Practicing outside the scope of one's capabilities
3	#11 - Unsupervised mid-level (nurse practitioner or physician assistant) care
0	#12 - Failure of communication with patient
0	#13 - Patient non-adherence with recommendations for care
4	#14 - Delay in emergency response or failed to follow emergency response protocol
2	Other (including unavailability of medical record)
109	Total number of extreme departure lapses (many cases had more than one extreme departure)

D. Preventable Deaths

In 2007, three cases were identified as preventable. Table 6 shows the causes of death and Table 7 lists the eleven lapses in care observed in the three cases.

Table 6. Causes of preventable death.

Cases	Cause of Death
1	drug induced hepatitis
1	adrenal insufficiency, disseminated cocci
1	pulmonary embolism

3	Total

[13] Table 7. Types of lapses in care (extreme departures) in preventable deaths.

Lapses	Types of Lapses in Care (Extreme Departures)
1	#1 - Failure to recognize, identify or adequately evaluate important symptoms or signs
3	#2 - Failure to follow established guidelines for evaluation and/or management of specific condition
1	#3 - Delay in access to care sufficient to result in harm to the patient
1	#4 - Failure to adequately pursue abnormal test results
1	#5 - Failure of provider-to-provider communications including botched handoffs
0	#6 - Fragmentation of care such that individual responsibility for patient is waived
0	#7 Surgical/procedural complication resulting in iatrogenic injury
1	#8 - Medication prescribing error
2	#9 - Medication delivery error
0	#10 - Practicing outside the scope of one's capabilities
0	#11 - Unsupervised mid-level (nurse practitioner or physician assistant) care
1	#12 - Failure of communication with patient

0	#13 - Patient non-adherence with recommendations for care
0	#14 - Delay in emergency response or failed to follow emergency response protocol
11	Total

It is instructive to look at each of these cases in some detail. As seen in the case examples below, more than one extreme departure lapse occurred in each of the cases. A single lapse was not enough to result in a patient's death, but multiple lapses lined up to produce an adverse outcome.

Case 1. Drug-induced hepatitis.

> A 40-year-old Spanish-speaking patient was prescribed isoniazid (INH) for a poorly documented "positive" tuberculin skin test (medication prescription error). Baseline liver functions were ordered but apparently not done (failure to follow clinical guidelines). One month later, a liver function panel showed elevation of the liver enzyme ALT to 4 times normal. This report was not noted until two months later (failure to identify abnormal lab result), when the patient presented with dark urine, and jaundiced eyes that had been present for at least one month (failure to communicate effectively with patient about the warning signs of INH hepatitis). The patient died three weeks later of INH-induced hepatitis (several notations indicated the patient was "Spanish speaking only" yet another note indicated "patient understands English").

Case 2. Acute adrenal insufficiency in a patient on high dose continuous steroids.

A 62-year-old patient died after abrupt cessation of high dose dexamethasone which he had been receiving continuously for 4 1/2 months. On 4/3/07, he had a 48-hour delay in evaluation for high fever, chest pain and night sweats (delay in access to care). The [14] initial evaluation consisted of chart orders without a clinical note, and he was then seen several times in clinic with abnormal chest x-rays, shortness of breath, and low oxygen saturation (88-91%) but was managed as an outpatient (failure to properly evaluate/manage "red flag' symptoms and signs). Coccidioidomycosis pneumonia and pneumothorax were diagnosed on 4/09/07 and he was started on antifungal therapy. He was in hospital continuously and had lumbar laminectomy on 5/25/07. High dose dexamethasone was prescribed post operatively for severe pain and weakness, and this dose was not tapered (failure to follow clinical guidelines for prescribing steroids for pain). He remained in the hospital for 4 1/2 months after the laminectomy because of postoperative staphylococcal wound infections. During his prolonged hospital stay, a cardiologist evaluated another patient with the same last name and for several days the patient received medication, atenolol, intended for the other patient (medication delivery error) without adverse consequence. When discharged back to prison on 10/09/07, neither the transfer note nor the phone conversation between the discharging physician and the accepting physician indicated his prolonged course of high dose dexamethasone (failure of provider-to-provider communication at time of handoff). He did not receive dexamethasone on return to prison on 10/9/07. Two days later he developed hypotension and tachycardia, was hospitalized (at a different hospital from which he had been discharged), intubated, received vasopressors and high dose antibiotics but no corticosteroids and died as a consequence of unrecognized acute adrenal insufficiency.

Case 3. Pulmonary embolism.

A 39-year-old patient died of preventable pulmonary embolism. He was placed in 5-point restraints after ingesting razor blades. Restraints were ordered because he was having auditory hallucinations directing him to hurt himself. The patient reported he had failed to receive his antipsychotic medication for a few days (medication delivery error). The restraints were re-ordered for five days continuously despite indication that the patient was quiet and cooperative during this period (failure to follow clinical guidelines – medically non-indicated restraints per restraint protocol). Range of motion (therapy) was ordered but not documented to have been given at the ordered frequency. The patient had sudden cardiac arrest and autopsy showed massive pulmonary embolus at the bifurcation of the pulmonary artery.

IV. Discussion

A. Lapses in Care and Preventable Death

Predictability and preventability are two different concepts. It is difficult for even trained, highly qualified physicians to determine that a death is preventable using retrospective case review. To a large extent, "preventability is in the eye of the beholder." It is easier to identify predictable deaths, based on cause of death (patients with certain types of conditions such as metastatic or high grade cancer, congestive heart failure, or multiple chronic diseases, commonly believed to shorten life expectancies).

[15] In the CPHCS death review process, reviewers are asked to identify all lapses in care, and to grade each lapse as either a "simple departure" or a "serious (extreme) departure" from the standard of care. Simple departures are much more common than serious departures, and there are often disagreements in committee over each designation. For this review, only the serious (extreme) departures have been collected and tabulated.

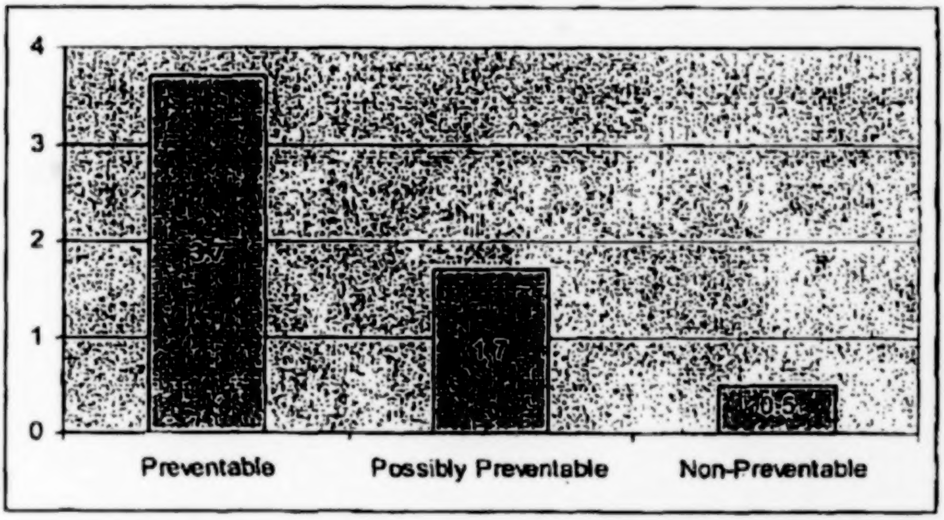
There has been strong support for the 14-category taxonomy of lapses. The list has been reviewed and accepted by all of the members of the Clinical Support Unit who conduct the death reviews. Three other nominees for inclusion did not make the final list. These were "failure to address addiction," "failure to identify and treat serious psychiatric conditions" and "failure to address spiritual emptiness."

Lapses in care occurred in all three types of deaths-preventable, possibly preventable, and non-preventable-but lapses occurred most frequently for the preventable cases (Table 8 and Figure 2). Preventable deaths had an average of 3.7 lapses per death, possibly preventable deaths had an average of 1.7 lapses and non-preventable deaths had an average of 0.5 lapses. These findings support the idea that adverse outcomes, in general, are a consequence of multiple errors: the Swiss cheese model of adverse events in which multiple "holes" in the system all line up.

Table 8. Number of lapses by preventability.

Preventability	Lapses	Deaths	Lapses per Death
Preventable	11	3	3.7
Possibly preventable	109	65	1.7
Non-Preventable	172	327	0.5

Figure 2. Average number of lapses per death by preventability.



[16] B. Trends in Death Rate and Preventability

Tables 9-11 show significant declines in the CDCR death rate from the first quarter of 2006 through the second quarter of 2008.

Table 9. Death rates per quarter and annualized among California inmates, 2006-2008.

Quarter	Number of Deaths	Number of Inmates	Quarterly Rate per 100,000 inmates	Annualized Rate per 100,000 Inmates
Q1 2006	124	170,475	72.7	290.9
Q2 2006	108	172,561	62.6	250.3
Q3 2006	103	173,101	59.5	238.0
Q4 2006	93	172,528	53.9	215.6
Q1 2007	112	172,284	65.0	260.0
Q2 2007	100	173,312	57.7	230.8
Q3 2007	91	172,645	52.7	210.8
Q4 2007	94	171,444	54.8	219.3
Q1 2008	99	169,949	58.3	233.0
Q2 2008	87	170,983	50.9	203.5

Table 10. Change in the death rate among California inmates, 2006 to 2007.

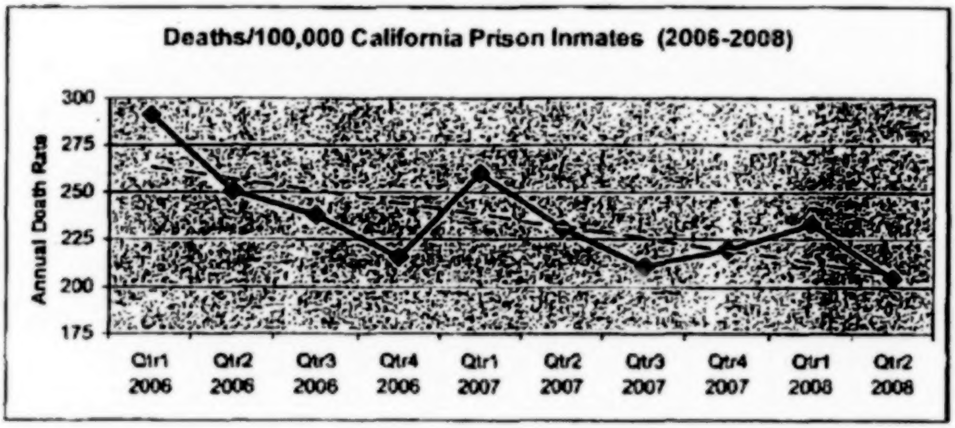
Year	Number of Deaths	Number of Inmates	Annualized Rate per 100,000 Inmates	Change
2006	428	172,166	248.6	-
2007	397	172,421	230.3	-7.4%

Table 11. Change in the death rate among California inmates by prior year quarters 1 and 2 combined, 2006-2008.

Quarter	Annualized Rate per 100,000 Inmates	Change
Q1-2 2006	270.5	–
Q1-2 2007	245.4	-9.3%
Q1-2 2008	218.2	-11.1%

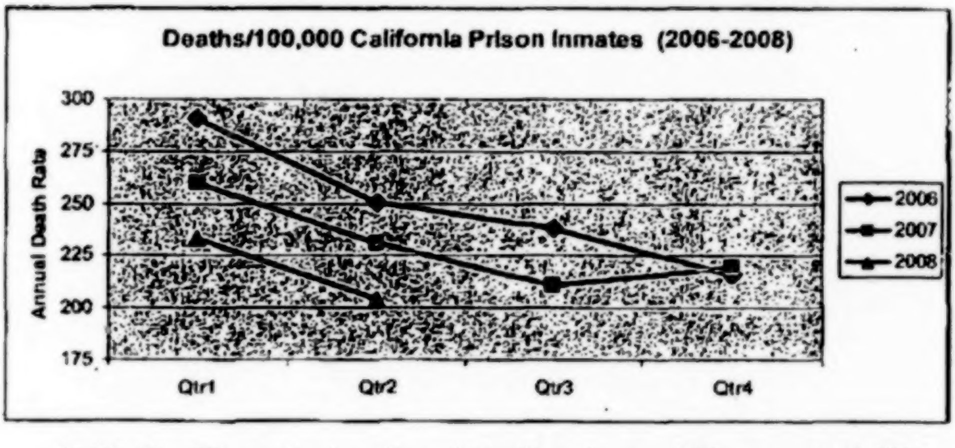
Figure 3 displays the decreasing trend in overall mortality from January 2006 through June of 2008 as well as the calculated linear regression line.

[17] Figure 3. Trend in annualized mortality rate per 100,000 inmates, 2006-2008



Displaying the same data in lines one-year long demonstrates the seasonal variation pattern, correlating with circulation of winter viruses, that is usually seen in population-based mortality studies (Figure 4).

Figure 4. Trend in annualized morality rate per 100,000 inmates, 2006-2008, displayed by year



[18] C. Trends in the Attribution of Preventability

Compared to 2006,[3] in 2007 there were far fewer cases identified as preventable and more that were identified as possibly preventable (Table 12 and Figure 5). Because the death review process was less standardized in 2006, it is likely that the total number of preventable deaths was under-estimated in the analysis of the year 2006 deaths..

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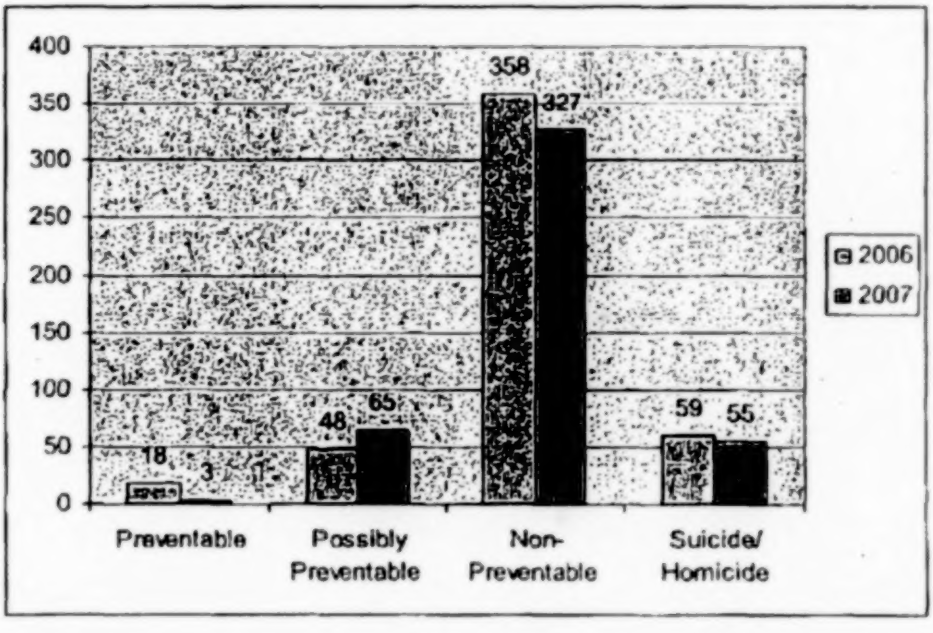
[3] Imai K. Analysis of CDCR Death Reviews 2006. August 20, 2007. Found at: www.cphcs.ca.gov/resource.aspx

Table 12. Types of preventability of deaths among California inmates, 2006 and 2007.

Year	Preventable	Possibly Preventable	Non-Preventable	Suicides / Homicides
2006	18	48	358	43 / 16 (total 59)
2007	3	65	327	33 / 22 (total 55)

Figure 5 Number of deaths by preventability, 2006 and 2007. The suicides and homicides are included as non-preventable deaths and shown separately as well.



D. Interventions to Decrease Preventable Deaths

The vast majority of lapses in care do not lead to death, but in cases of preventable death, there were a higher number of lapses per case. Strategies to decrease or mitigate lapses, if successful, will decrease the number of unnecessary deaths. Table 13 shows the total number of lapses in care identified an all 396 death review cases.

[19] Table 12. Summary of lapses of care (extreme departures), 2007.

Lapses of Care Types (Extreme Departures)	# of Lapses in the 327 Non Preventable Deaths	# of Lapses in the 65 Possibly Preventable Deaths	# of Lapses in the 3 Preventable Deaths	Total # of Lapses
#1 - Failure to recognize, identify or adequately evaluate important symptoms or signs	52	43	1	96
#2 - Failure to follow established guidelines for evaluation and/or management of specific condition	19	6	3	28
#3 - Delay in access to care sufficient to result in harm to the patient	31	20	1	52
#4 - Failure to adequately pursue abnormal test results	13	5	1	19
#5 - Failure of provider-to-provider communications including botched handoffs	4	5	1	10
#6 - Fragmentation of care such that individual responsibility for patient is waived	10	7	0	17
#7 - Surgical/procedural complication resulting in iatrogenic injury	1	3	0	4
#8 - Medication prescribing error	14	7	1	22
#9 - Medication delivery error	5	3	2	10
#10 - Practicing outside the scope of one's capabilities	4	1	0	5
#11 - Unsupervised mid-level (nurse practitioner or physician assistant) care	6	3	0	9
#12 - Failure of communication with patient	0	0	1	1
#13 - Patient non-adherence with recommendations for care	5	0	0	5
#14 - Delay in emergency response or failed to follow emergency response protocol	3	4	0	7
#15 - Other	5	2	0	7
Total	**172**	**109**	**11**	**292**

[20] The most frequent lapse was the failure to recognize, evaluate and treat important signs and

symptoms. Fully one-third of all identified lapses (96/292 or 33%) occurred in this category. In fact, lapses numbers 1, 2, and 3 together account for 60% of all identified lapses. The Receiver and CPHCS have already begun many steps intended to reduce lapses in care in the California prison system and more are planned. The following lists interventions to be taken to address each of the 14 lapses.

#1. Failure to recognize or evaluate important signs and symptoms.

The majority of these lapses involved patients presenting for non-routine care with chest pain, shortness of breath, abdominal pain, severe headache, dizziness, acute confusion, new neurological symptoms, weight loss, and abnormal vital signs including low oxygen saturations. Many of these cases occurred after clinic hours, at night and on weekends, when healthcare staff are most isolated.

a. Strengthening hiring criteria. New criteria for employment have been adopted, which includes board certification or demonstrated competence in a primary care specialty. As of August 2008, 85 providers have left employment or been suspended and these have been replaced with providers who meet the new criteria. As the committee continues to meet, the number of poorly qualified providers has significantly declined.

b. Redesign of on-call policy and system. The PPEC will soon revisit the on-call policy to address the issue of after-hours evaluation of red flag symptoms.

c. Reducing provider isolation. Renovation of clinical areas in existing prisons and creation of the

Receiver's seven new healthcare facilities will reduce the current physical isolation of providers. Unlike providers in community hospitals and clinics who can readily consult with colleagues, CPHCS providers often find themselves making decisions in professional solitude.

d. Access-to-Care Initiative. A comprehensive redesign of the "sick call" (access to primary care) process is underway.

e. Provider case conferences and continuing medical education (CME).. The Clinical Support Unit now conducts regular case-based educational meetings at the individual prisons. Many are based on death review cases. Focused CME will be presented on the management of red flag symptoms.

f. Quarterly newsletter. A quarterly newsletter of the Peer Review Department began in September 2007. The newsletter contains articles on evaluation of critical clinical problems and highlights lessons from death reviews.

g. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#2. Failure to follow clinical guidelines.

These lapses involved failure to follow evidence-based guidelines of care for asthma, diabetes, chronic hepatitis C, suspected unstable coronary disease, congestive heart failure, and chronic pain management.

[21] a. Access-to-Care Initiative. The Receivership and CPHCS have recently begun the Access-to-

Care Initiative, which will create standardized, measurable, reliable, and sustainable access-to-care processes in the four domains of 1) reception, 2) sick call and primary care, 3) chronic disease care, and 4) specialty, infirmary and acute care. The first chronic disease initiative involves asthma, which was responsible for six preventable deaths in 2006 and two more in 2008. The changes created by this initiative will fundamentally change the way that medicine is practiced in CPHCS and should dramatically reduce lapses in these areas.

b. Promotion of disease guidelines. The Pharmacy and Therapeutics Committee continues to publish medication guidelines for common conditions. The chronic hepatitis C guidelines have recently been updated and will be rolled out in 2008-09. The pain management guidelines will be adopted and rolled out in 2009.

c. Availability of decision support at the time of care. Providers and nurses with access to web-connected computers now have access to UpToDate, the leading medical online reference resource, but continued deployment of health information technology will enable additional supports. Renovation of clinics and the Receiver's new healthcare facilities, as noted above, will also increase availability of support from colleagues.

d. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#3. Delays in access to care.

These lapses occurred throughout the spectrum of care, including lapses in triage, acute care, primary care, specialty care and higher levels of care (hospital and emergency department).

a. Access-to-Care Initiative. The Access-to-Care Initiative will generate practice changes in all of these major settings of care, especially the nursing triage, acute care, primary care, and specialty care domains.

b. Health Care Access Units. The Receiver has begun to establish dedicated health care access custody teams at each of the 33 prisons to ensure the availability of custody escorts.

c. Specialist and hospital provider network. The Receiver's initiatives in contracting and utilization management will improve availability and responsiveness of specialists and community hospitals. Cohorting chronically ill and disabled patients in the Receiver's seven new healthcare facilities will improve availability and quality of specialty and hospital care.

d. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#4. Failure to identify and pursue abnormal test results.

a. Primary care system redesign. A primary care system redesign will address this area, including creation of a culture of accountability.

[22] b. Health information technology. The clinical data repository will begin to be available to providers with computer connectivity in 2009.

c. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#5. Provider-to-provider communication.

These occur during handoffs of care, especially those involving specialty consultations, patient transfers from prison to prison, and transfers from prison to hospital or emergency department and back again.

a. Transfer communication. Contracted hospitals and specialists must be required to provide timely written and verbal communication at the time of transfer.

b. Primary care system redesign. A primary care system redesign will address this area, including creation of a culture of accountability.

c. Reducing provider isolation. Renovation of clinical areas in existing prisons and creation of the Receiver's new healthcare facilities will reduce the current physical isolation of providers and facilitate communication.

d. Redesign of on-call policy and system.

e. Health information technology. Computer connectivity and electronic records can help mitigate this lapse.

f. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#6. Failure of provider to assume responsibility for the patient.

This occurs when a system of care is fragmented and episodic, as is the case in the majority of the 33 prisons.

a. Primary care system redesign. A primary care system redesign will address this area, including creation of a culture of accountability.

b. Redesign of on-call policy and system.

c. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#7. Surgical/procedural complication.

a. Competency of specialists. If poor quality specialists are identified, their contracts should be pulled and new pools of specialists and hospitals should be found.

b. Specialist and hospital provider network. The Receiver's initiatives in contracting and utilization management will improve availability and responsiveness of specialists and community hospitals. Cohorting chronically ill and disabled patients in the Receiver's new seven healthcare facilities will improve availability and quality of specialty and hospital care.

[23] #8. Medication prescribing error.

a. Pharmacy system redesign. An electronic pharmacy system with embedded reminders and clinical guides is being rolled out (Maxor Guardian).

b. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#9. Medication delivery error

a. Pharmacy system redesign. An electronic pharmacy system with embedded reminders and clinical guides are being rolled out (Maxor Guardian).

b. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#10. Practicing outside the scope of one's capabilities

a. Redesign of privileging policy. New credentialing policies include "tiered credentialing," a privileging system in which providers are only privileged to work in settings where they have demonstrated competence.

b. Reducing provider isolation. Renovation of clinical areas in existing prisons and creation of the Receiver's new healthcare facilities will reduce the current physical isolation of providers and facilitate ready assistance for providers.

c. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#11. Failure to supervise mid-level providers (nurse practitioners and physician assistants)

a. Regular mentor/supervisor. All mid-level practitioners were assigned a regular physician mentor / supervisor in the 4th quarter of 2007.

b. Redesign of mid-level care. Initiatives in progress include primary care redesign, chronic care initiative, and creation of tiered credentialing.

c. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#12. Failure to communicate effectively with patient

a. Primary care system redesign. Redesign of primary care will support trust in physicians by patients (and vice-versa) and will enhance the roles of RNs and other members of the care team in communication, including patient education.

b. Local work with Men's Advisory Councils (MACs) and Women's Advisory Councils (WACs).

#13. Patient non-adherence with recommendations for optimal care without appropriate effort by providers to educate or convince the patient

a. Primary care system redesign.

[24] b. Access-to-Care Initiative. The Access-to-Care Initiative is promoting the chronic care model and care management initiatives.

c. Patient peer education. The Access-to-Care Initiative includes peer education as one component of the chronic care model.

d. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

#14. Delay in emergency response or failure to follow emergency response protocol.

a. Emergency Medical Response Initiative. The Emergency Medical Response Initiative will touch every prison in the coming months.

b. Nursing practice review. The nursing staff have recently implemented new procedures for nursing practice review.

c. Local peer review. These and all other types of lapses should be discussed at a local level and incorporated into the local peer review processes.

E. Other Areas of Potential Improvement

Death reviews focus attention on a range of lapses in the processes of care in specific cases by specific clinicians. Valuable as this is, it is important to remember that medical record reviews shed only limited light on system contributions to errors and poor outcomes. Regarding hand hygiene, for instance, universally recognized as important to patient health outcomes, medical records reflect neither individual compliance with accepted practice nor the availability of necessary facilities and supplies. The CDCR has been notorious for its lack of hand-washing facilities in clinical areas.

The interventions mentioned above include a number of system strategies that go beyond individual provider recruitment and education. In addition, the interventions below highlight several of the more important "macro" interventions that will be necessary to facilitate reliable patient care.

1. Creating/redesigning the primary care system.

   The current system of care is episodic and characterized by patient-physician relationships that are often adversarial and symptom-driven. It should be possible to decrease serious lapses in care by changing to a primary care model that is characterized by an ongoing patient-physician relationship with built-in advocacy for patients and accountability for outcomes. Poorly trained and poorly motivated providers should continue to be replaced with providers who are competent to deliver primary care. Primary care physicians should help create and lead interdisciplinary patient management teams designed to manage panels or populations of patients.

2. Creating a chronic disease care model of care.

   The practice of medicine in many, if not most, of the prisons continues to be episodic and focused on acute symptoms rather than patient-centered continuity, prevention, and chronic disease management. With better health information technology, it will be [25] possible to identify patients at risk for preventable death based on age, functional status, and/or diagnoses. These patient groups have more chronic diseases, take more medication, and are subject to more testing, more hospitalizations, more specialist visits, and more medical handoffs. The chronic care model has proven effective in preventing unnecessary morbidity and mortality, producing measurable improvements in overall care, and reducing waste through implementation of care management, redesigned team-based processes, patient education, and decision support.

3. Improving supports for good primary care practice.

   The medical record system is still paper-based. Individual records, if available, are often in shambles, and essential patient medical information is often missing. The new pharmacy processes are far from fully implemented, so medication dispensing and administration are still fraught with potential for delays and errors. Even when California's largely rural prisons can recruit adequate numbers of physicians and nurses, specialists and ancillary services staff are often unavailable.

4. Facility upgrades and seven new facilities (10,000 bed project).

   The CPHCS clinical staff has been working in clinical areas that are dirty, cramped, crowded, noisy, and poorly equipped. Efficient team care, as called for in the chronic care model, is physically impossible where the requisite team members cannot fit in the clinical space, as is true for the majority of CDCR's yard clinics. The volume of care often far exceeds capacity, as at Avenal State Prison, where the 7525 inmates get care in spaces designed for 2320. Crowded patient care areas promote errors and prohibit confidentiality. Recruitment and retention of professional staff will be problematic so long as clinic environments are isolating and flagrantly unprofessional. There are plans to improve and enlarge the clinical areas in existing prisons, but these clinic remodels have only just started, and they will not address the challenge of providing adequate care in rural areas to large populations of patients heavily burdened with chronic disease. The 10,000 bed project will cohort sicker patients in urban or near-urban facilities, increase access to care, and dramatically improve efficiencies in care.

5. Redesigning the ways in which patient information is handled at care transitions.

   The inmate patient population is challenging. There is a high prevalence of dual diagnoses (serious mental illness coexisting with physical illness), chronic hepatitis, HIV infection, and drug and alcohol addiction. Depression is endemic. The extraordinary rate of transfers in the California prison system creates opportunities for botched handoffs and the loss of critical bits of clinical information at the point of transfer. The development of health information technology and the 10,000 bed project will decrease the number of botched transitions in care.

6. Collaboration with custody.

   Security issues complicate both access to care and provision of care in prisons. Taking patients for care outside the prison is a remarkably complex process. Cell searches can result in confiscation of regular medication, and lags in replacement may lead to lapses in [26] delivery of necessary medications. A strong relationship between custody and the medical department is essential when redesigning almost any aspect of care in CDCR.

F. Conclusion

Death rates in the CDCR are significantly decreasing in part because the high-quality CPHCS peer review process has resulted in the replacement of 85 potentially dangerous providers with new well-qualified providers.

The death review process offers an important but narrow window on the quality of healthcare delivery systems. There are inherent limitations on the information provided by this process. It focuses largely on physician practice as documented in the medical record. It does not reveal the adequacy of staffing; the performance of the interdisciplinary team working with the provider; the provision of information to support planned care rather than episodic care; the availability of decision support during patient encounters; the performance of supervisors, managers, and executives; the organization's commitment to education and training; or the adequacy of equipment and the physical environment.

In its continued examination of the causes of poor outcomes in American healthcare, the Institute of Medicine (IOM) has noted the need for "fair and just systems of safety that acknowledge both the individual and system contributions to successful as well as adverse events while emphasizing the systems approach to error reduction."[4] Healthcare systems must distinguish human errors from willful negligence and intentional misconduct, but they must also build strong defenses into the work environment. The IOM report quotes safety expert James Reason, "We cannot change the human condition, but we can change the conditions under which humans work."

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[4] Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academy Press; 2004.

In his Turnaround Plan of Action, the Receiver has committed to establishing the array of prerequisites to care that is safe, effective and efficient. The IOM has repeatedly pointed out that "piecemeal approaches will not be successful."[5] Recruiting new providers will not yield sustainable improvements in mortality if those providers are left practicing in the cramped yard clinics of existing CDCR prisons. The clinic upgrades and 10,000 bed project, together with computer connectivity and health information technology, will make it possible to achieve critical clinical redesigns with concomitant improvements in quality and cost-efficiency. Without them, care will continue to be wasteful and unsafe.

Patient safety requires creation of a culture in which clinicians readily identify mistakes and system vulnerabilities and in which all staff share in the responsibility for optimal patient outcomes. Given appropriate supports, such a culture should be possible in California's prison healthcare system. Sustaining and continuing improvements in lapses in care, unnecessary deaths, suffering, and waste will depend upon continuing progress of the Receiver's multifaceted interventions.

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[5] *Ibid.*

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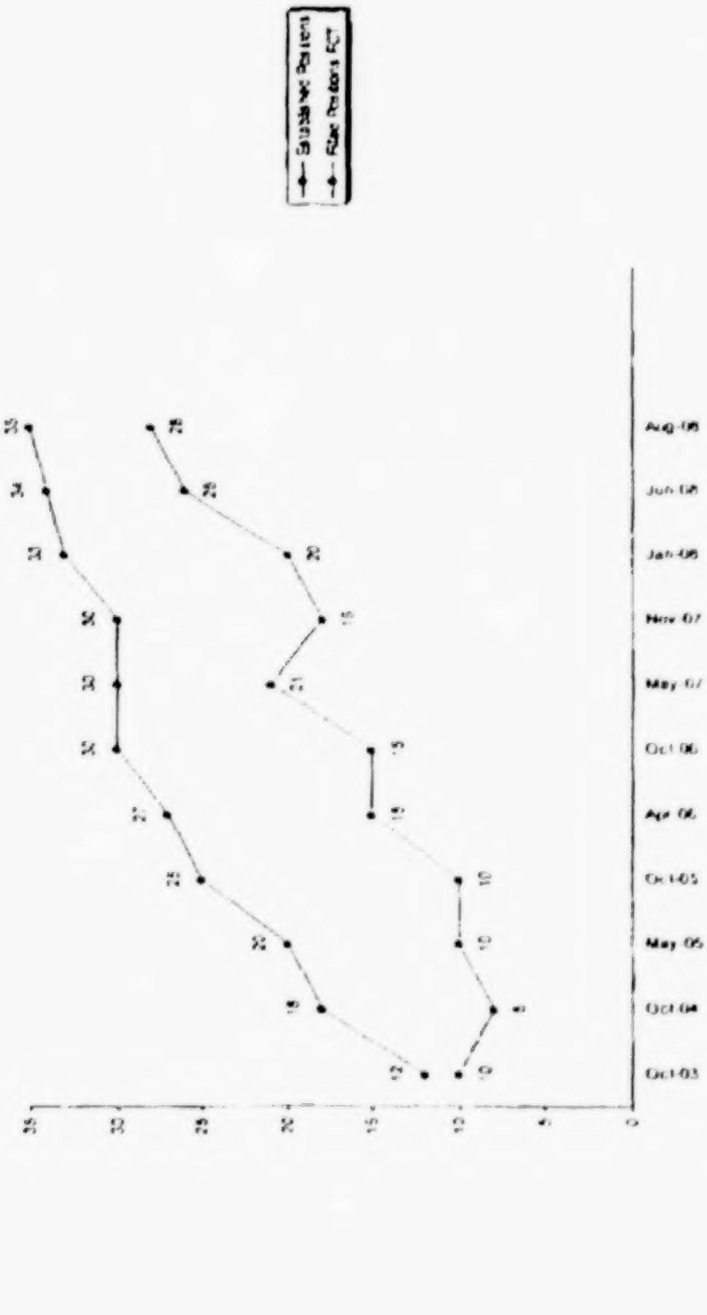
PLATA V. SCHWARZENEGGER
COLEMAN V. SCHWARZENEGGER

3-JUDGE PANEL

DEFENDANTS' TRIAL EXHIBIT No. 1235

CHIEF PHYSICIAN AND SURGEONS STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

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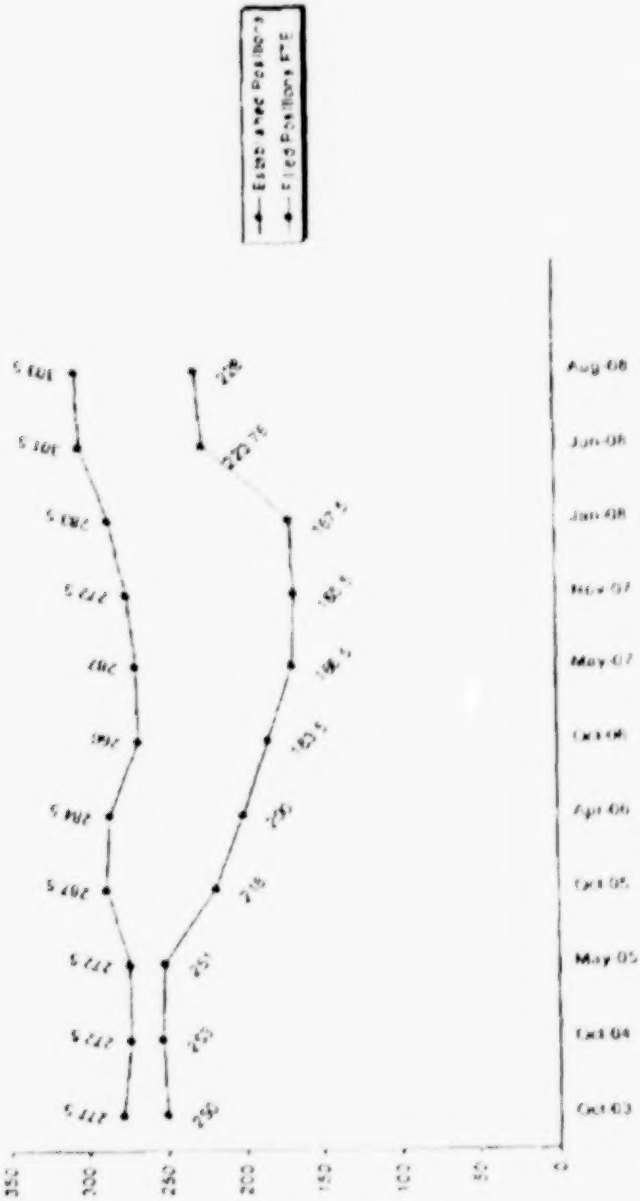
PHYSICIANS STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



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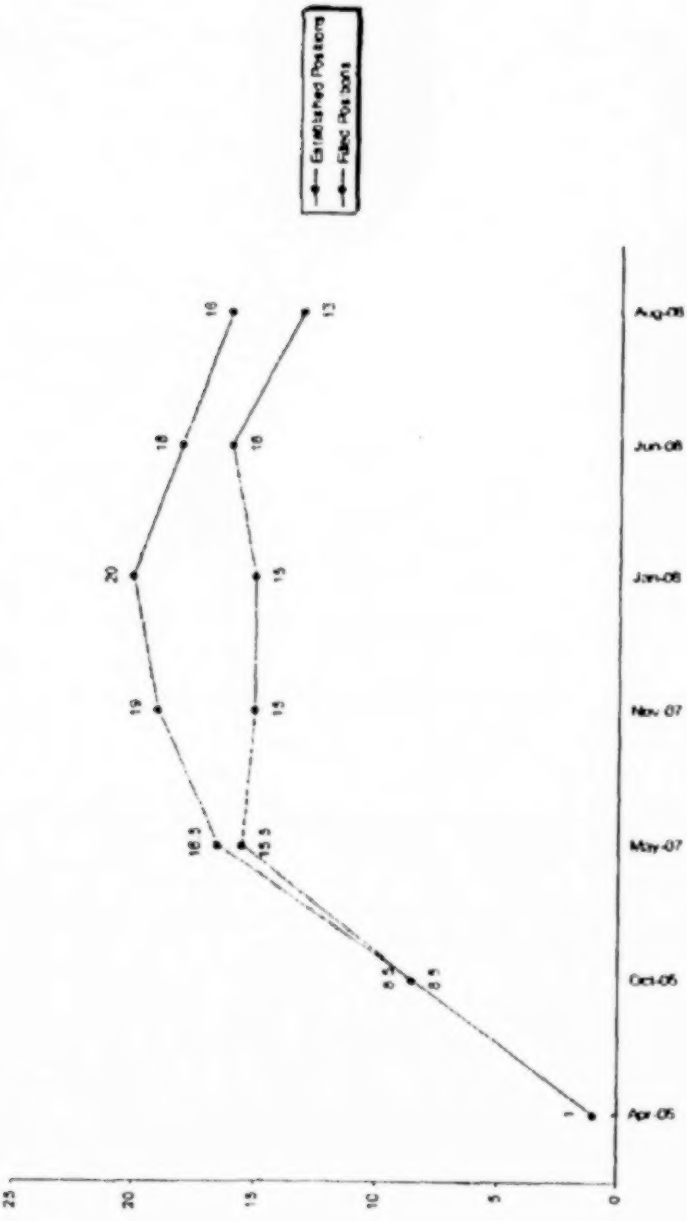
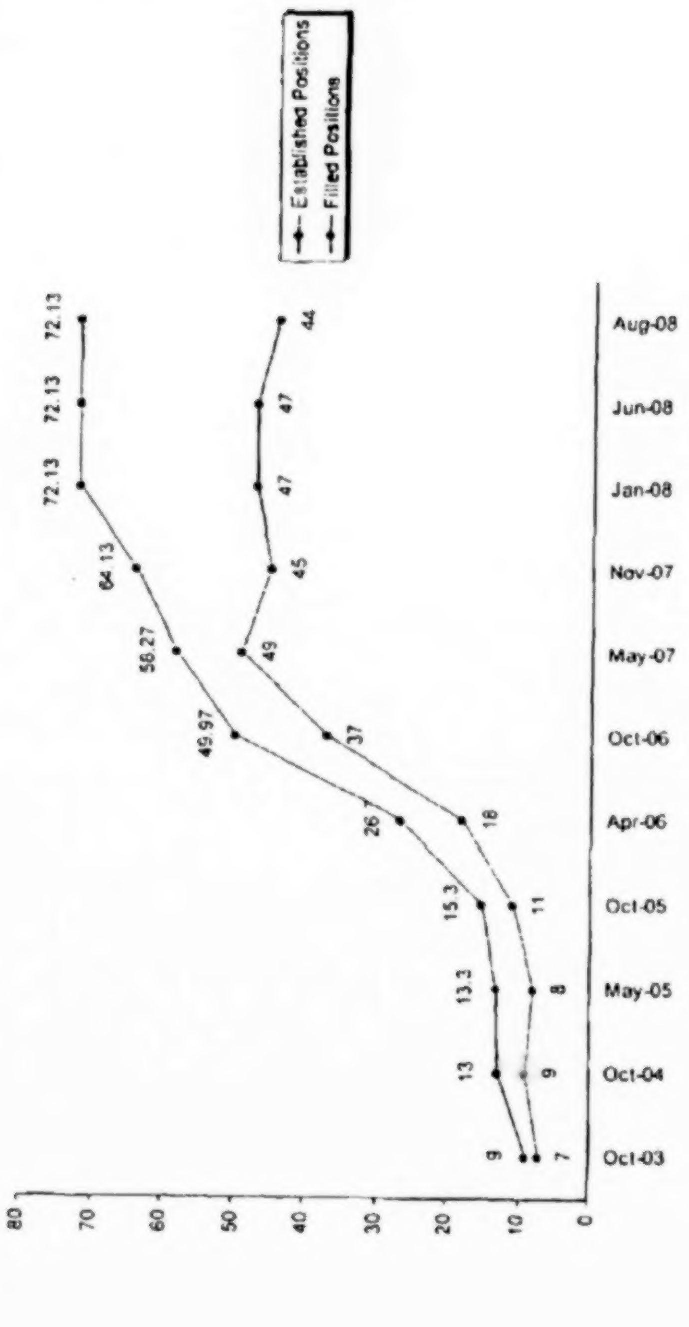
PHYSICIANS ASSISTANTS STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

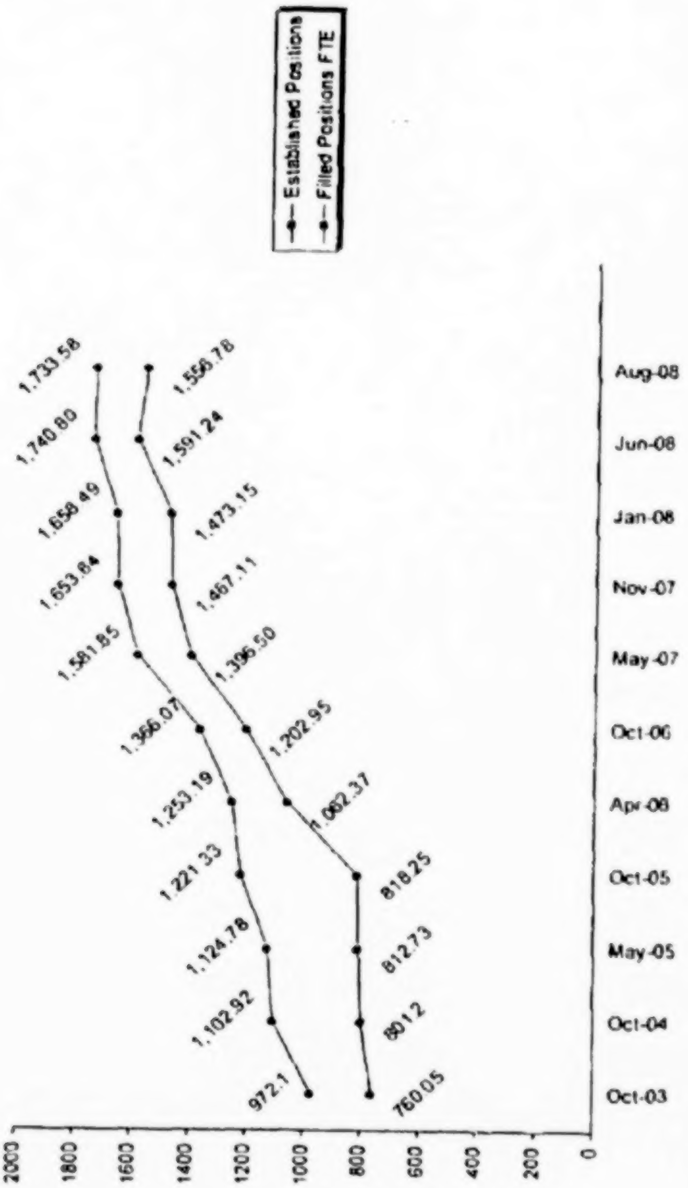
NURSE PRACTITIONER STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

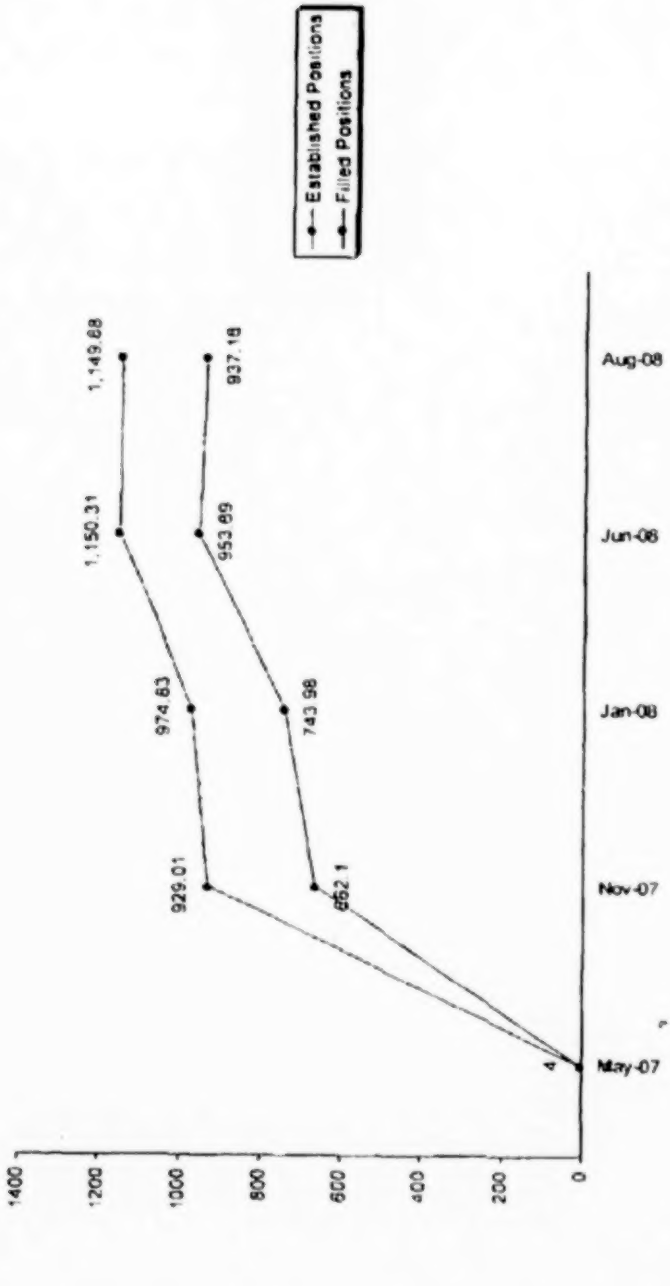
REGISTERED NURSES STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

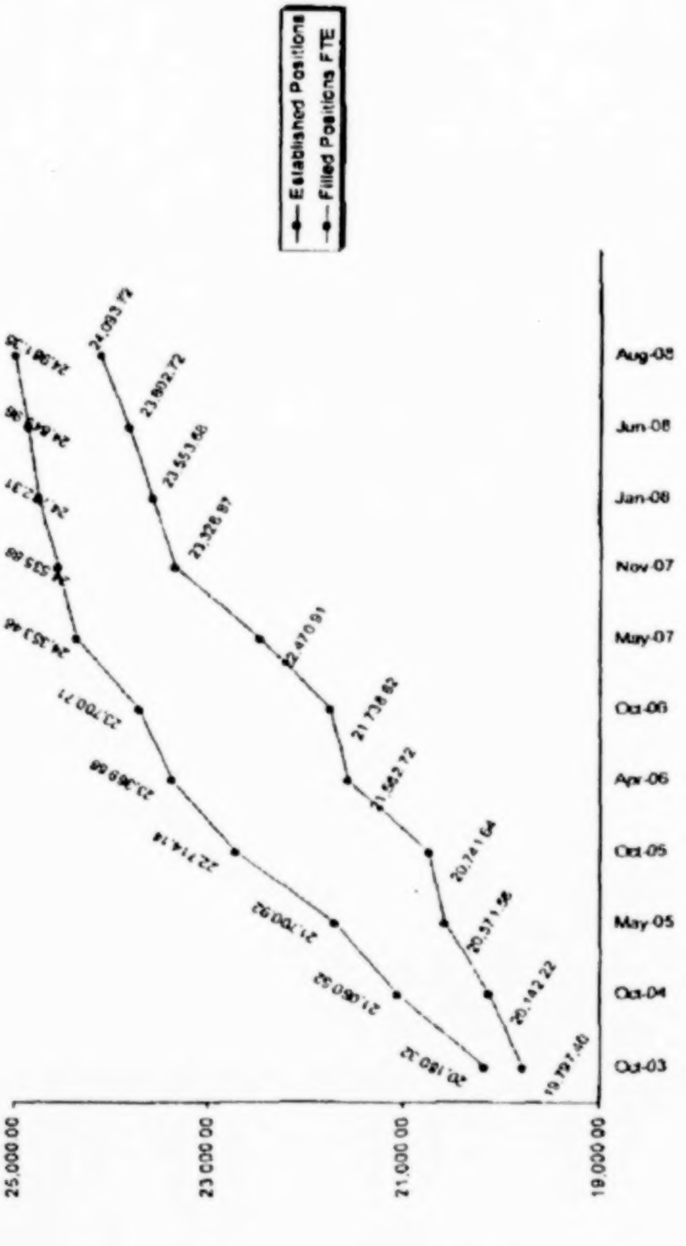
LVNS STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

CORRECTIONAL OFFICERS STAFFING TRENDS FROM OCTOBER 2003 - AUGUST 2008



Notes: Filled positions means number of full time employees. Filled position does not include any additional positions filled by outside contractors.

Source: Staffing Reports from SCO's Established Positions File. Defs.' Trial Ex. No. 1263

[1] CALIFORNIA REHABILITATION OVERSIGHT BOARD MEETING

HELD ON

SEPTEMBER 4, 2008

AT

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

ALUMNI CENTER

6000 J STREET

SACRAMENTO, CALIFORNIA

Reported by:

CARRIE PEDERSON
CSR No. 4373, RPR, RMR, CRR
Job No. 60606

[2] BOARD MEMBERS

DAVID R. SHAW, Inspector General, Chairman of the Board

MATTHEW CATE, Secretary, Department of Corrections and Rehabilitation

DEBRA JONES, Administrator, Adult Education Programs (designee for Jack O'Connell, State Superintendent of Public Instruction)

JOSE MILLAN, Vice Chancellor, California Community Colleges (designee for Diane Woodruff, Interim Chancellor)

RENEE ZITO, Director, California Department of Alcohol and Drug Programs

STEPHEN MAYBERG, Director, California Department of Mental Health

SUSAN TURNER, Professor, University of California, Irvine

BRUCE BIKLE, Professor, California State University, Sacramento

GARY STANTON, Sheriff, Solano County

WILLIAM ARROYO, Regional Medical Director of Los Angeles County Department Of Mental Health

[3] LOREN BUDDRESS, Chief Probation officer, San Mateo County

[4] OFFICE OF THE INSPECTOR GENERAL STAFF

BARBARA SHELDON, Chief Counsel
LAURA HILL, Executive Director
ANN BORDENKIRCHER, Board Secretary

[5] PANEL

CAROLE HOOD, Chief Deputy Secretary, Adult Programs, Department of Corrections and Rehabilitation

BARRY KRISBERG, Ph.D., National Council on Crime and Delinquency

CLARK KELSO, Federal Receiver, California Prison Health Care Receivership Corporation

DEBORAH HYSEN, Chief Deputy Secretary, Facility Planning, Construction and Management, CDCR

[6] PUBLIC COMMENT

DAVID WARREN, Lobbyist, Taxpayers for Improving Public Safety

SUSAN LAWRENCE, M.D., The Catalyst Foundation

PATRICK WILSON, Project Manager, Don's Plumbing Co.

RAY MILLER, Consultant, Organizational Research

[7] BE IT REMEMBERED that on Thursday, September 4, 2008, commencing at the hour of 9:43 a.m., at California State University, Sacramento, Alumni Center, 6000 J Street, Sacramento, California, before me, CARRIE PEDERSON, a Certified Shorthand Reporter in the State of California, duly authorized to administer oaths and affirmations, the following proceedings were had:

* * *

CHAIRMAN SHAW: Good morning, everyone. My name is David Shaw, and as the Inspector General, I'm the chairperson of the California Rehabilitation And Oversight Board, and I would like to call this meeting to order.

I would first like to introduce our staff and board members. With us today from the Inspector General's Office is Barbara Sheldon, our chief counsel and counsel to the board; Ann Bordenkircher, the board secretary, is sitting next to her; Heather Konvalin back in the back, and Jamie Sammut who will help you with board materials at the back table; Laura Hill who is our executive director for the board.

I'd like to thank all the board members

* * *

[112] Thank you.

At this time we're going to take a lunch break, and we will reconvene at one o'clock back in this room.

(Noon recess taken.)

CHAIRMAN SHAW: Okay. It's 1 p.m., 1:05 or so. I'd like to reconvene California Rehabilitation Oversight Board, and we'll move on to agenda item number eight, prison healthcare needs. I'd like to welcome Clark Kelso, the federal receiver.

Mr. Kelso, the board members are looking forward to hearing the latest from the receiver's office on healthcare. Take it away, Clark. Good. Thank you.

MR. KELSO: This is on, I take it.

Good afternoon. Thank you for inviting me to join you here today and accommodating my schedule for today. I appreciate that. I do have a Powerpoint presentation. I should ask, about how long would you expect I should be talking, or do you have an expectation?

CHAIRMAN SHAW: We programed an hour for you.

MR. KELSO: Oh. Well, goodness. I'll [113] stretch, I'll stretch.

DR. BIKLE: We'll ask you some questions.

MR. KELSO: I'll be happy to answer questions as I go along.

What I've done in the presentation here is essentially described the state of the receivership as of August and September, and I'm happy, then, to provide additional details and my answers, or, if need be, we can supplement any of my responses with additional materials.

I'm going to assume some general—and tell me if I shouldn't, but I'm going to assume some general understanding of the litigation background here and the fact that the receivership has been in existence for almost two years now. I assume that that's appropriate, or should I give you a little bit of background about that?

CHAIRMAN SHAW: Any board members would like to have a—

MS. ZITO: I would.

MR. KELSO: A quick review of how we got here. The quick review is that there have been a series of class actions challenging various aspects of the constitutionality of healthcare [114] being provided by California's—in California's prisons, a series of class actions, not just one, a number of them, and this litigation has been under way for, in some cases, 15 years or so.

The particular case that led to the creation of the receivership is a case called Plata versus Schwarzenegger. It began in an earlier administration, and it was a challenge to the constitutionality of how medical care was being delivered. The basis for the challenge was the 8th Amendment, cruel and unusual punishment clause, and in 2002, essentially there was a settlement—or a stipulation rather—between the plaintiff's counsel and the state that the court accepted in which essentially there was a concession that prison medical care was not up to constitutional standards.

The stipulation contained—was a very lengthy stipulation—contained lots of provisions about what the state then was supposed to do to bring its prison medical care system up to constitutional standards. This is something like a 60-page order. It had lots of things that the state was supposed to accomplish.

Over the course of the next four years, [115] between 2002 and 2006, essentially the state did not accomplish very many of those, and ultimately the court decided to appoint a receivership, which was an extraordinary remedy, one of the most extraordinary remedies that a federal court uses in this sort of class action litigation, and the receivership—the theory behind a receivership is that if a defendant is unable to comply with court orders or unwilling to comply, that the federal court has the ability to appoint someone who will then exercise the powers of that agency essentially as a receiver in a bankruptcy would. The receiver comes in and takes over a portion or all of the affected agency. And in this case the court ordered the creation of a receivership where the receiver becomes responsible for and has all of the powers of the secretary of the Department Of Corrections And Rehabilitation with respect to medical care, and the order takes those powers away from the gubernatorially appointed secretary for corrections and rehabilitation.

The court entered that order, appointed the first receiver, Bob Sillen. Bob spent the first 12 to 18 months essentially beginning to [116] build his own staff and doing an assessment of conditions in the prisons in order to make a decision about how best to correct those conditions. Under Bob's direction, the receivership and staff had assembled a good six or seven hundred pages worth of planning documents and had 35 to 40 different initiatives that they were going to be pursuing to bring medical care up to constitutional standards.

The court, late in 2007, reviewed those six or seven hundred pages with the assistance of an advisory panel and decided that this just wasn't quite enough of a plan that the court could approve, and the court had been seeking from Mr. Sillen basically a plan for a good 12 months, and the court essentially got a little bit impatient that it did not get a plan in place and decided that the receivership was at a point where, in addition to getting a final plan produced, it was clear we were going to be entering a phase where, in the court's words, the receivership needed a different style of leadership. I think it's fair to say Mr. Sillen's style of leadership was a highly visibly combative one, and it helped, very early [117] on, get the legislature's attention and the administration's attention and the state's attention, but the judge ultimately decided that to finish out the planning program in more collaborative style of leadership was required.

The court appointed me in January of this year to replace Bob, and I've really done essentially two things since then of—I think of significance. The first is we did take the six or seven hundred pages and reduce it to an understandable, relatively short plan of action, what we call a turnaround plan of action. That's available on our website, and that's what will be the basis for the presentation that I'll give very shortly.

And the second thing I've been doing is then trying to secure all of the necessary resources to implement that plan, and I'm very close to completing essentially that task as well. There are a lot of other things going along on a day-to-day basis, but in terms of sort of leadership role that I exercise as receiver, those are the two big accomplishments that we needed to—we needed to achieve this year.

Is that a sufficient background for [118] members? The intention is, in terms of the future, that the receivership stays in place as long as it takes to bring the system up to a constitutional level, and at some point, then, the receivership winds down, goes out of existence. The court probably will continue to monitor the state's progress for some period of time, but the clear hope of the court is and my mission is to raise the level of care quickly to constitutional level so that the court can end the case. The federal court has no great desire to be running the state's prison healthcare system.

Let me make a few brief remarks about other cases. This case, Plata, is medical care. There are three other important cases in the federal courts dealing with healthcare. One is a case called Coleman versus Schwarzenegger. That deals with mental health, and Judge Karlton has been presiding over that case for a good 12, 14 years, and it's basically sort of the same constitutional challenge. Judge Karlton, in that case, did not appoint a receiver. In that case, the judge appointed a special master, which is another thing that a federal court can do, who

* * *

[121] the environment, quite favorably because I am a federally court-appointed receiver, and that does give me rather extraordinary freedoms that a normal department director or cabinet secretary does not have, and I was fairly confident simply because I knew so many of the control agency directors and players and was familiar with the legislature and the governor's office, that I would be able to secure a great deal of cooperation in what we're doing, and in fact that has been proven to be true.

We have very few disagreements at this point with the control agencies or even with the legislature.

Basically all of the resources that I have asked for—with one exception, all of the resources we've asked for, we've been *given, and* so *I'm* feeling rather upbeat about the progress that we know is already being made and about the progress that will be made over the next three or four years.

Let me describe a little more, then, about what the plan is, and this plan is available, of course, on our website. The basic vision here of the turnaround plan is up on the screen. I can take you through it very quickly, [122] and, *again, I'll* take *questions* at *any* time. I'm used to being interrupted.

As soon as practicable. The court does not want to be in this business for the next ten years. There was, I think, a concern that the receivership was heading *towards something* where it could easily be 10, 15 years before it would finish its work, and that simply is too long a time frame. Federal courts have, frankly, had a rather spotty *record in managing* state and local institutions whether it's prisons, jails, schools. There are a number of areas where federal courts have involved themselves in administrative matters, and the *record* is not all that great at times. Some of the school cases have dragged on for 25, 30 years of federal court supervision. Judge Henderson would like to retire and go fishing, and so I told him I would get this done more quickly. My own horizon, my estimation is we will have turned the system around in about four years. It's a fairly aggressive time frame given what you're going to see in the rest of the plan, but, you know, we'll never know if we can make it unless we try.

It has to be constitutionally adequate.

* * *

FOR ARGUMENT

Supreme Court, U.S.
FILED
NOV 8 2010
OFFICE OF THE CLERK

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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NOTICE

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Coleman v. *Schwarzenegger*/*Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK JFM P, C01-1351 TEH (E.D. Cal./N.D. Cal. Nov. 3, 2008) (order denying motion for dismissal) 257a

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and in the Appellants' Appendix to the 09-1233 Jurisdictional Statement at the following pages:

Coleman v. *Schwarzenegger*/*Plata* v. *Schwarzenegger*, Nos. 2:90-cv-00520 LKK-JFM-P, C01-1351-TEH (E.D. Cal./N.D. Cal. Jan. 12, 2010) (order to reduce prison population) 1a

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[1] UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 11/19/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings

San Francisco, California
Tuesday, November 18, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Katherine Wyatt, CSR 9866, RMR
Official Court Reporters, U.S. District Court

[6] will consider extending the time for plaintiffs and CCPOA only if the defendants agree to give up part of their time to plaintiffs.

We should note that the joint pretrial statement calculations are based on 5-1/2 hours of actual court time per day, while the court's calculation reflects 5-3/4 hours per day. So keep that in mind.

Second, the excerpts from Robin Dezember's depositions that plaintiff seeks to introduce into evidence appear to be admissible statements of a party opponent. Thus, pursuant to the court's November 12th order, defendant shall have five court days to file and serve any objections to these deposition excerpts and any counter designations thereto.

Third, plaintiffs and defendants are hereby ordered to file by 8:30 a.m. tomorrow morning revised copies of their revised exhibit lists that include objections and responses thereto. The ones you filed didn't include objections responses.

Fourth, defendants' motion for reconsideration of the courts' order denying defendants' motion to dismiss or, in the alternative, motion for summary judgment is denied. Having carefully considered the defendants' motion for reconsideration, the court finds no basis for altering its original decision.

Finally, defendants' motion for reconsideration of the courts' oral ruling prohibiting evidence of constitutional [7] compliance at trial is also denied. If, as defendants contend, there are no longer any constitutional violations at issue in Plata or Coleman, then there will be no reason to continue either the receivership in Plata or the special mastership in Coleman. Those are matters for an individual court to decide, and defendants should, therefore, file motion for appropriate relief before me or Judge Karlton individually in those cases. These three-judge court proceedings are not the place for those arguments.

Having made these preliminary rulings we will proceed with opening statements. Remember that each statement will be no more than 15 minutes. You may proceed when you are ready, counsel.

And I will ask you, Ms. Espinosa, to let counsel know when they have five minutes remaining.

The clerk: I will.

Judge Henderson: You may proceed, counsel.

Opening statement by Mr. Specter

Mr. Specter: Good morning, Your Honors. My name is Donald Specter. I am appearing on behalf of the plaintiffs in this case.

I stand before you today representing more than 150,000 individuals who are completely dependent on the Governor and the officials of the California Department of Corrections and Rehabilitation for all of their basic needs. Among those

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[46] plans in the system, improved provision and access to specialty care and hospital services, improved peer review and death review programs. He's working on the establishment of a comprehensive, safe and efficient pharmacy program, including the development of the drug formulary and the rollout computerized pharmacy system—

The Clerk: Time's up, counsel.

Mr. Mello: One more moment.

—designed to improvement medication management in CDCR institutions.

Crowding has never been identified as a significant barrier to constitutionally adequate medical care in California's prisons. In fact, at no time before the filing of this motion to convene a three-judge panel was crowding identified as a significant impediment to the delivery of care, let alone a primary barrier to it.

Defendants, however, do not dispute that crowding impacts services and programming in CDCR prisons, including the delivery of medical care. The evidence will show, however, that crowding is not the primary, most important, principal cause of the alleged unconstitutional delivery of medical care.

The state takes very seriously its obligations to inmates and the public. This is evidenced by the funding it devotes to CDCR healthcare systems, and it is undisputed that medical care has improved dramatically in the last few years.

* * *

[56] clinicians and sufficient beds.

It's not about the release of any inmates, and certainly it's not about the release of the mentally ill inmates. It's about providing beds, providing those specialized beds, those specialized mental health clinicians to care for the mentally ill inmates.

Defendants respectfully thank this court for hearing the Coleman defendants' separate opening statement.

Opening statement by Mr. Kaufhold

Mr. Kaufhold: Good morning, may it please the court. My name is Steve Kaufhold from Akin, Gump, Strauss, Hauer & Feld. I am counsel for the legislative intervenors and speaking this morning on behalf of the defendant intervenors in this action that oppose the issuance of a prisoner release order.

W^ appreciate having the opportunity to participate in this phase of the litigation and to make heard the voices of the scores of individual law enforcement personnel, district attorneys, county officials and state legislators that we're privileged to represent.

In order to proceed beyond this first phase of the bifurcated proceedings, the plaintiffs must demonstrate by clear and convincing evidence that, quote, "crowding is the primary cause of the violation of a federal right," end quote, and the plaintiff classes must meet the burden separately in the Plata and Coleman cases.

[57] In addition, the law enforcement, district attorney, and legislative intervenors are participating in this phase in order to emphasize two key issues.

First, from the evidence that is provided—has been provided to date by the plaintiff classes, the plaintiffs will not be able to make the requisite showing that crowding is the primary cause of any violation of their federal rights. This is particularly true in light of the testimony of plaintiffs' own experts during their depositions and the high clear and convincing standard and burden of proof that they must satisfy.

Second, the plaintiff classes have disclaimed the need to demonstrate that there are any current constitutional violations of their federal rights, and our understanding is that the court has held that no such evidence will be presented in this phase of the proceeding. We respectfully believe this ruling is contrary to the terms of the Prison Litigation Reform Act accordingly—

Judge Karlton: Sir, I am the very source of patience. If you believe that, I'll sell you a piece of the Brooklyn Bridge really cheap. Twice this Court has said we will not receive that evidence. You have made as clear a record as you can. Please don't waste our time.

Mr. Kaufhold: I am not trying to waste your time, Your Honor.

Judge Karlton: But you are.

[58] Judge Henderson: Move on.

Judge Karlton: Move on.

Judge Henderson: You preserved the record. Don't make it in your opening statement. The record is clear you don't like that ruling.

Mr. Kaufhold: And since we—

Judge Henderson: move on, counsel.

Mr. Kaufhold: Yes, Your Honor. Since we had not raised that, I just wanted to make that clear.

Judge Karlton: Move on, counsel. I think you must have some trouble understanding. Move on.

Mr. Kaufhold: That was my second and final point, Your Honor. Thank you for your consideration.

Judge Henderson: Okay. I think we will take a 15-minute recess before we present our first witness and—

Judge Karlton: Sir, were you speaking for the DA and Law enforcement as well?

Mr. Kaufhold: Yes, Your Honor, I was, but not for the counties.

Judge Karlton: But not for the counties.

Ms. Keck: My name is Anne Keck for Sonoma County intervenors.

Judge Karlton: I'm having trouble hearing you, Anne.

Ms. Keck: May it please the court, the counties and Sonoma County intervenors are not going to present a separate

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[62] (Thereupon, the witness was sworn.)

The Clerk: Have a seat. Speak into the microphone and state and spell your full name for the record.

The Witness: My name is Pablo Stewart. P-A-L-B-O S-T-E-W-A-R-T.

Ms. Whelan: Your Honors, Dr. Stewart's qualifications are set forth in paragraphs 1 through 19 of his November 9th, 2007 report, and in his co, which is appended a to both his initial November 9, 2007 report and his August 15, 2008 supplemental report.

We offer both of his reports into evidence at this time. And they appear as Coleman docket numbers 3217 and 3221 through 3221-2.

Ms. Tillman: Your Honors, Lisa Tillman on behalf of the Coleman defendants. We state the objections we previously filed with this court in regards to those expert reports.

Judge Karlton: That's fine. You really don't have to do that anymore. If you stated it, we're aware.

We will become aware of it, if we hadn't, when we sit down and try to resolve this case. Thereupon—

Dr. Pablo Stewart

Was called as a witness on behalf of the plaintiffs, and after having been first duly sworn, was examined and testified as follows:

* * *

[66] Coleman class members were housed and also housing units where Coleman class members were not housed.

During the course of these—of my walking portion of the tour, I was able to speak with a variety of custody staff, as well as clinical staff, asking them very particular questions on the provision of mental healthcare. And also during these walking tours I had the opportunity to conduct—and, again, this is over the course of all of my tours—approximately 60, what I'll describe as formal interviews, where I had private interviews with various members of the Coleman class. And those people I also had the opportunity to review their unit health record, and, you know, to review their medical care and psychiatric care.

In the addition to these formal interviews, which was approximately 60 over the course of these six prisons that I visited, I had an opportunity to speak with at least 100 inmates, some of them in the Coleman class, some of them not in the Coleman class.

And these were I would describe as very informal. I would see people waiting in the pill line, and I would talk with them.

I would go to various housing units and speak with various members of the Coleman class. And again, that totaled to around 100.

Q. You were asked to form an opinion as to whether overcrowding [67] in the California prison system is the primary cause of constitutional violations in the delivery of medical and mental healthcare.

What did you conclude?

A. I concluded that overcrowding was the primary cause of the ongoing constitutional violations.

Q. Can you explain why you reached that conclusion?

A. A variety of reasons that I used to reach this—that opinion. I'm very aware that the Coleman class has had the ability of being monitored by the Coleman court for a number of years. I believe it began around 1994, 1995.

Unidentified speaker: Your Honor, we can't hear the witness, if you could ask him to speak up.

Judge Karlton: Can you speak up? I must confess there's a lot of echo, so it's hard for me to fully hear.

The Witness: Your Honor, I'm sorry. Is this better here?

I'm rarely accused of being soft spoken, so I was taken a little aback by that.

Getting back to what I—why I felt that the overcrowding was the primary cause of the ongoing constitutional violations is that based on my experience as being a court-appointed monitor during a federal oversight of an institution regarding mental healthcare, it's remarkable to me that after over 10 years of very close monitoring and hundreds

* * *

[75] But as equally as dangerous is the fact that in a prison word gets out really quickly based on my experience. So it's the people who would utilize mental health services are very aware that these are the conditions in which they would be placed if they come forward expressing their suicidal thoughts to a staff member, to a custody officer, to another inmate who would then report it.

And in my experience, this significantly inhibits people from coming forward to expressing their true state of their mental illness, their true levels of suicidal ideation or plan, et cetera.

So that's, to my view, a very dangerous aspect of the prolonged use of these very inadequate housing modules.

Q. You also mentioned your tour at Salinas Valley State Prison.

Ms. Whelan: And I believe we also have some pictures from that. Tour, if we could show plaintiffs' trial exhibit 338, pictures 11, 12 and 13.

By Ms. Whelan:

Q. Dr. Stewart, Could you describe what we're seeing here?

A. What we're seeing there is—it's really difficult to comprehend. This is where people who cannot— who are in mental health crisis, who are unable to access mental health crisis beds because of the fact of overcrowding have to wait. These are cages. People need to sit upright.

Ms. Tillman: Objection. Mischaracterizes the [76] evidence by use of the term "cages."

Judge Henderson: I didn't hear you, counsel.

Ms. Tillman: I'm sorry. Lisa Tillman speaking. Objection to the term "cages." That mischaracterizes the evidence. It's inflammatory and argumentative.

Judge Henderson: Well, I don't know how to characterize it.

Judge Karlton: It is what it is.

Ms. Tillman: I believe the court special monitor has found this to be holding cells, and other arrangements are called "therapeutic modules."

Ms. Whelan: Your Honors, these are also part of their objections.

Judge Henderson: Let's call it that a rose by any other name—

The Witness: These therapeutic modules that are very cage-like are used to—

Ms. Tillman: I'm going to object to the use of the term "therapeutic module." This picture is not of a therapeutic module. It is of a holding cell.

The Witness: These holding cells—

Ms. Tillman: I'm sorry that the expert doesn't recognize the difference.

The Witness: Your Honor, regardless of what they are called, the Coleman class member who is in psychiatric crisis [77] who has been identified as needing to be housed in a mental health crisis bed is forced to sit upright in these cages—excuse me—in these units during the day where there's no toilet. There's no water. There's no health or safety facilities there, and while they are waiting for placement in a mental health crisis bed. And this occurs at the Salinas Valley State Prison.

By Ms. Whelan

Q. Dr. Stewart, you're also a psychiatrist. Were you able to monitor and visit and look into the medication management systems at the prisons during your tours and through your review of documents?

A. Yes.

Q. And can you describe to the court what you found and what your conclusions were?

A. Regarding the medication management system, it is my opinion that the medication management system currently as it exists in the California Department of Corrections and Rehabilitation is overwhelmed. There are just too many people that are prescribed too many medications for the system to adequately address.

At Solano State Prison inmates have to routinely choose between going to morning breakfast versus getting their pills.

In other settings, where there is persistent lockdowns the staff take the medicines to the cells and [78] administer it through the food ports. And they spend literally seconds, as fast as it takes to pop out whatever pills there are from the blister pack, and hand them to the food port is how long the person stays—the staff stays in front of the Coleman class member who is being prescribed a variety of very potent antipsychotic antidepressant and mood stabilizing medications.

The pill lines, people waiting long periods of time and, again, when they get to the front of it they are there for a few seconds to get their medications.

I saw no evidence of—the term that I use is "clinical management."

There's no evidence that the person administering the medication has the time or the opportunity to ask the person about the presence of any untoward side effects; of any problems they have in taking the medications, in general; medication adherence or compliance; as well as doing a quick check on the efficacy of the medicine.

So this gets back to the fact that speaking with the chief psychiatrist at Mule Creek State Prison, doctor Fowler, says that there's no objective outcome measures that look at whether or not anything that the psychiatrists do, any therapeutic interventions— and in this case medications—are having any positive effect for their clients, because there's no feedback loop because of the overwhelming number of people that are supposed to be given medications in these literally seconds [79] a person stands in front of you.

There's no feedback loop to the prescriber. There's no feedback loop from the prescriber to the person given the medication. It's clear to me the system is overwhelmed.

This is further evidenced by my discussions with the DMH staff. Dr. Ghandi, who is in charge of the DMH programs at the Vacaville Psychiatric Program looked at people being admitted to the DMH units there. And it was over 70 percent, I believe. It was a very large number, 70 or 80 percent of the Coleman class members that were being admitted to the DMH units had no evidence or minimal evidence in their bloodstream of any of their prescribed medications, which further evidenced to me that will medication system cannot—

Ms. Tillman: Object to the extent that goes into hearsay, Your Honors.

Judge Henderson: We just can't hear you, counsel. I'm sorry.

Ms. Tillman: Objection, hearsay. He's offering it now for the proof.

Judge Henderson: Overruled.

The Witness: my conversations with Dr. Ghandi, as well as other staff members, were just. Part of my basis of my opinion stating that medication management system is completely overwhelmed.

Judge Karlton: Doctor, how is it—I don't [80] understand how is it that the bloodstream doesn't reflect the taking of the drugs. What do you understand that to mean?

The Witness: The most obvious answer to that, Your Honor, is that, in fact, when these people come—the Coleman class members come in front of the pill distributing staff, that they cannot ensure that they are, in fact, taking it.

The fact that there's no medication evidenced in their bloodstream means that they are not taking the medication because there's not enough time spent by the clinical staff to ensure that, in fact, people are taking the medicine.

And this is further evidenced, Your Honor, by very—a very well-used psychiatric medication. It goes by the brand name of "WELLBUTRIN" it's a very good antidepressant. And it has been taken off the formulary, meaning that the inmates can no longer be prescribed that because it does have a very small risk of abuse.

If you store them up, you take a bunch of them at once, you can sort of get a little bit of a high, kind of like a psycho stimulant.

This medication has been taken off the formulary. And to me, that's just admission on the part of the CDCR that they can't adequately supervise the distribution of medication.

By Ms. Whelan

Q. We only have a couple of minutes left. And I know in your reports you talk about challenges that clinicians and staff [81] members face. And can you talk about how these conditions affect clinicians on a daily basis?

A. What I was struck with—and, again, I had the benefit of being involved in the Gates matter and the Madrid matter back in the '90's. And so I was able to compare my two experiences.

What I found overwhelmingly, again, due to the overwhelming population pressures placed on the system, that clinical staff are placed in these untenable situations where they have—they are forced to make these decisions to put a person in psychiatric crisis in a unit that is still up here on the stand—on the screen.

I mean, that's an untenable position to be placed in as a clinician. I mean, something like this could even jeopardize someone's licensure, to participate in this type of care. And I saw it time and again than clinical staff are forced into making these very, very difficult decisions because of the fact of overcrowding.

Ms. Whelan: Thank you.

The Court: Cross-examination?

By Ms. Tillman:

Q. Good morning, Dr. Stewart.

A. Good morning.

Q. I understand that you are a board certified psychiatrist, correct?

[82] A. Yes, I am.

Q. You are not an internist, correct?

A. I'm sorry?

Q. You're not an internal medicine specialist?

A. An internal medicine specialist? I'm not an internal medicine specialist. I did a year of internal medicine before I started my psychiatric training, but I'm not an internist.

Q. And that year was over 25 years ago; would that be right?

A. It was actually 26 years ago.

Q. Who's counting?

Your career has been dedicated working as a Board Certified Psychiatrist. Presently you hold an academic teaching position with University of California, correct?

A. Yes.

Q. And you occasionally consult on various litigation matters, correct?

A. I consult on a variety of matters. Some of them include litigation, yes.

Q. You mentioned earlier that you worked on what was known as the *Gates* case, which was one of the first-class action cases brought against the Department of Corrections and Rehabilitation involving just one institution, correct? The California Medical Facility at Vacaville?

A. Yes, it did just involve the California Medical Facility.

Q. And it involved a multiplicity of issues ranging from [83] medical care, mental healthcare to other issues involving different inmates with disabilities under the Americans with disabilities act, correct?

A. Yes, it did.

Judge Karlton: I'm having a little trouble hearing you. I'm trying to read it off the screen because I'm having a little trouble understanding you. I'm not sure if it's correctable.

Ms. Tillman: I'll see if I can get a little closer to the microphone, okay?

The Clerk: Speak into the microphone, counsel.

Ms. Tillman: Better?

The Clerk: Into it.

Ms. Tillman: Okay. Thank you.

By Ms. Tillman:

Q. Now, you mentioned in your report that you've worked on various correctional matters involving the correctional system of Michigan, correct?

A. A juvenile institution in Michigan, yes.

Q. And a correctional system in Georgia, correct?

A. That was the juvenile justice system in the state of Georgia, Yes.

Q. And correctional system in New Mexico, correct?

A. I was defendant's expert in New Mexico.

Q. And obviously none of those systems that you worked on in

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[85] tanks." there were units that were exclusively used for the placement of people we were treating, yes.

Q. And that type of separation of these enhanced outpatient program patients was something that you found appropriate for their care, correct?

A. Yes.

Q. And you're aware, aren't you, that the same separation of enhanced outpatient program patients from the general population occurs within the California Department of Corrections and Rehabilitation, right?

A. Yes, it does.

Q. And, in fact, in retrospect now that you have the opportunity of looking back at the time period when you served as the director of forensic services for the city and county of San Francisco, now some 20 odd years later you found that that system met the constitutional elements laid out by the Coleman court and was, indeed, constitutionally adequate, correct?

A. Yes. We have talked about this before where during the period of time in the late '80's—around '88, '89—I remember, because the Giants were in the World Series that year, and it was the earthquake year, that it was my opinion—again, retrospectively—that the city and county was meeting their constitutional requirements that have subsequently been laid out by the Coleman court.

Q. And that is the only correctional system that you are aware [86] of; isn't that right, that is or was meeting those constitutional mandates?

A. It was the only system that I had personal experience with, yes.

Q. And you would agree that the elements of a constitutionally compliant mental healthcare system involve uniform policies and procedures to provide care, sufficient beds to provide care, sufficient clinical staff, and competent staff to provide care, a suicide prevention program and a recordkeeping system, correct?

A. Well, in addition to those things that you mentioned it also calls to have an adequate system for the identification, the screening and referral of people who require mental healthcare within the system. And also states that people within the system have access to appropriate levels of psychiatric care, including medications. And that they need to have an adequate recordkeeping system, as well as a suicide prevention program.

Q. Now, in terms of adequate screening and identification of the mentally ill inmates, wouldn't you agree that the fact that the Coleman mental health population has increased over the years, even increased at a time when the general population was decreasing, would indicate that, indeed, mental health clinicians are doing their job in screening and identifying those inmates who are needing mental healthcare services?

A. I don't know if you can necessarily make that leap, based on [87] what I personally observed at the DVI reception center where they have over 500 intakes on average a week. And about 25 percent of those inmates, based on my conversations with Dr.

Coppola, the Chief Psychiatrist, acknowledged that they are mentally ill.

That the screenings that I saw were done in non-confidential settings. They were done in group rooms. They had a high possibility of not catching everyone who could seriously be suffering from mentally illness.

Q. But they are catching more than ever, aren't they?

A. Well, I think what that speaks of, again, that shows what I've been trying to say all morning is that the system is so overwhelmed that it's creating more and more mentally ill. That even in this overwhelmed system they are identifying some of them.

Q. When you speak—

Judge Karlton: Excuse me.

Is it your view that it is likely that there is more than 25 percent of the prison population is suffering serious mental illnesses?

The Witness: Your Honor, based on what I saw at the reception center the staff there are absolutely overwhelmed on a daily basis by the number of people who come in to be screened. And then, the screenings that do occur occur in a group setting where there's no confidentiality.

[88] So in looking at the sheer number, as well as the manner in which the screenings are done, one could opine that they are not catching everyone, and you're only getting the most severe.

By Ms. Tillman

Q. You were speaking about the screening that occurs in a reception center, correct?

A. Yes.

Q. And you saw a single reception, correct?

A. Yes.

Q. That was at a dual location institution, correct?

A. Yes, correct.

Q. You haven't toured the other reception centers throughout the 33 institutions of the California Department of Corrections, have you?

A. I have not.

Q. And have you collected any data showing that as a person stays with the California Department of Corrections and Rehabilitation for a longer and longer period of time there's an increased likelihood of that person becoming mentally ill?

A. I don't know exactly what you mean by "data," but during the course of my tour—and now I'm speaking specifically of my tour of the Solano State Prison—where there was in use one of these dorms, triple-bunk dorms where there are just tremendous number of people in there given the space, I interviewed several [89] class members that one—two—two of the class members were suffering from staph infections that they got while living in these unhealthy conditions.

But in addition, that they admitted that they had no history of mental illness prior to being placed in these dorms. And that during the course of their housing in these dorms where there's an absolute lack of privacy, there's an absolute lack of any sort of adequate space, the lights are on all the time, there's this—it sounds like you're on a runway of an airport, how loud it is in there. That these people over time—

this one person in particular is reporting that after awhile they are running these fans because it's so hot there during the summertime that he started hearing voices within the fans.

He started getting delusional. He started getting paranoid just because of the housing setting.

Q. But you would admit, wouldn't you, that you've not actually compared the percentages of inmates with mental illness at reception centers versus the percentage of inmates at main line institutions that have been transferred from reception to a main line institution who have a mental illness, correct?

A. I'm sorry. I lost your question in there.

Q. You would agree, wouldn't you, that you've made no analysis comparing the number or percentage of inmates at a reception center who have mental illness versus the number or percentage of inmates at a main line institution who have mental illness, [90] have you?

A. I have not.

Q. You've talked to a lot of different people during your tours of—what was it—five institutions, correct?

A. Five different institutions, six tours.

Q. And during those tours, what, you spent a day, sometimes a half a day at each institution?

A. Yes.

Q. Some of your opinions were based on talking to inmates, correct?

A. Yes.

Q. And some of these inmates were not people that you would find to be normally trustworthy, would you?

A. I don't know what you mean by that.

Q. Some of the people that you spoke to were staff of the California Department of Corrections, correct?

A. I'm sorry. Were staff at the California Department of Corrections?

Q. Staff, yes.

A. That I didn't believe what they were telling me?

Q. I said:

"Some of the people that you spoke to were staff of the Department of Corrections, correct?"

A. Yes.

Q. But you haven't had the opportunity, have you, to look at [91] ongoing set of measurements or data regarding the actual delivery of mental healthcare services, have you?

A. Well, no. I think I have. I've extensive review of the master's reports of various reports that the master has put out. In addition to—I don't know if he refers to them as "quarterly reports," but suicide report, master's report on overcrowding.

So—and the master in Coleman has done extensive data collection, if you will, around the actual provision of care throughout the system. So I would disagree with that.

Q. But you would defer to the special master's findings of fact concerning various measurements of these different elements of a constitutionally-adequate mental healthcare system?

A. I certainly would take that into consideration.

Q. You understand that the special master has a team of psychiatrists as well as psychologists and attorneys that work to monitor these institutions, correct?

A. Yes.

Q. You would agree that the special master has provided monitoring reports almost every six to nine months since the inception of the monitoring in this case, correct?

A. I couldn't swear to what the frequency is. I know that I think he's up to 19 or 20. So how many that is, spread over the time.

Q. You haven't received all those reports, have you?

[92] A. I have not.

Q. You've received and reviewed, what, the 19th and the 20th monitoring reports?

A. I've certainly looked at the 19th and 20th, yes.

Q. And in those monitoring reports from the 19th to the 20th, did you see any express language finding—

Ms. Tillman: Let me strike that.

By Ms. Tillman:

Q. In the course of your work in reviewing these monitoring reports from the 19th round and the 20th round, isn't it correct that those monitoring reports made no recommendation to the court to do—to undertake any action to reduce the overall population of the Department of Corrections?

A. I'm not that familiar with what the final recommendations were, so I can't swear to that. I don't believe there were, however.

Q. Do you recall the special master's last monitoring report, the 20th round monitoring report, actually found that several institutions were in substantial compliance with the court-approved policies and procedures for providing mental healthcare?

A. I wasn't familiar with that.

Q. You don't recall that at all?

A. I don't recall that.

Q. Any reason to dispute that?

[93] A. Again, I just don't recall it.

Q. You are aware that the defendants have obtained court approval of their uniform policies and procedures for providing care to the mentally ill, aren't you?

Ms. Whelan: Objection, Your Honor.

Just because this is a very overbroad question, could you specify what order you're talking about?

Judge Karlton: I assume she's talking about the Protocols.

By Ms. Tillman:

Q. The revised program guide was approved by this Coleman court in March, 2006.

A. That's my understanding, yes.

Q. And let me just take a break and see if the court would like to take a lunch break at some point?

Judge Henderson: We're thinking of 12:30, counsel.
By Ms. Tillman:

Q. You've admitted that you're not very familiar with the revised program guide, correct?

A. I'm sorry?

Q. You're not very familiar with the revised program guide, correct?

A. I don't know that I ever said that.

Q. I believe you said it at your deposition, actually. Would you like me to refresh your recollection?

* * *

[124] condition dictates, and they haven't been able to do that.

Q. Now, you also mentioned a concern about holding cells. We saw a picture up on the screen a little while ago, and there's also some mention of therapeutic modules. Again, isn't it correct that the Coleman Special Master's team regularly tours these facilities and is aware of those holding cells?

A. They may or may not be.

Q. You've seen mention of the holding cells' usage in the monitoring reports from the Coleman Special Master?

A. Yes, and where I've seen them mentioned, he also mentions that they are unacceptable for acute psychiatric care.

Q. And isn't it correct that there's been no order to remove those holding cells, because when they are used appropriately, then the court approves their use?

A. I can't speak for the court. All I can tell you, from a clinical standpoint, those are horrible settings. Those are inadequate. There's nothing good. You wouldn't put people in there that require psychiatric care, waiting there for several days.

Q. Now, are you aware of what are called the therapeutic modules to enable group therapy to occur amongst inmate patients who pose very high risk of assault towards others or escape attempts?

A. I am aware that the department uses what you refer to as therapeutic modules, what I refer to as cages.

[125] Q. Isn't it correct that Dr. Metzner, who's been on the Coleman special master's team as a court-appointed expert for many years, was personally involved in the specifications used in those therapeutic modules?

A. I am. I'm aware that Dr. Metzner is involved in the Coleman monitoring team. Dr. Metzner and I worked briefly together on the Madrid case, and it's my understanding that it's his opinion that these, quote/unquote, "therapeutic modules" are adequate treatment, are adequate spaces to put mentally ill inmates.

Judge Karlton: I'm sorry. Are or aren't inadequate?

The Witness: It's my understanding, Your Honor, that Dr. Metzner feels that way.

By Ms. Tillman

Q. So when we talked about the housing of inmate patients, there may be differences of opinions amongst the experts on what is appropriate, isn't that right?

A. Now, housing or these various devices that are used to hold people in? Housing is very different than what we're talking about here.

Q. We'll take the latter. When it comes to therapeutic modules and holding cells, you apparently differ with the court-appointed experts, don't you?

A. Well, again, I come in from my perspective of being on the Gates monitoring team when the Coleman—when the original program guide was implemented as far as CCCMS, EOP, et cetera. [126] There was never a use of these therapeutic modules at that point.

In stepping away from them and coming back over ten years later, I feel they're absolutely inadequate and inappropriate for use in acutely mentally ill inmates. Let's make sure we understand that's what we're talking about.

People that are mentally ill—and if the security of the institution is at risk because people are so mentally ill that they have to be put in these modules, as you're calling them, then that speaks to how bad the quality of the mental healthcare is, because if the mental healthcare was being adequately provided to people, they wouldn't be at such a great risk of acting out.

So, in fact, you could look at it as an admission on the fact of the inadequacy of the mental healthcare that, in my opinion, is strictly due, primarily due to the overcrowding.

Q. It's interesting the Coleman special master's team has never indicated that the use of the holding cells or the therapeutic modules—

Judge Karlton: Are you testifying?

Ms. Tillman: Let me strike that.

Judge Karlton: I'm sorry, ma'am?

Ms. Tillman: I'll strike that. Thank you.

By Ms. Tillman

Q. You're familiar with the revised program guides' requirement

* * *

[130] people is a reflection of how bad the system is due to overcrowding that you can't hire people. My understanding is these are very good jobs as far as mental health jobs go, and if you can't fill these jobs, then it really reflects on how chaotic the current situation is.

Q. You would agree there's a national shortage of highly skilled mental health clinicians like psychiatrists, wouldn't you?

A. I understand we certainly are not—there's not enough psychiatrists to meet the current needs nationwide.

Q. And so even with the release of inmates from the Department of Corrections, defendants will still encounter the challenge of recruiting and retaining highly sought-after professional psychiatrists for the care of mentally ill inmates, won't they?

A. It certainly will require that they continue to put forth effort. But when the system is not so overwhelmingly crowded and when the working conditions are better—right now I was at DVI, and seven clinicians had to share one little, small, what used to be a broom closet. I don't care who you are, you are not going to—that's not a very nice working condition to work in.

So, it's more than just the number of clinicians; it's the overall system in which they're working in.

Q. So that would be your explanation for why the Department of Mental Health is more successful at recruiting mental health

* * *

[138] The Witness: Thank you, Your Honors.

Judge Henderson: Okay. You may call your next expert, Dr. Scott.

Ms. Norman: Plaintiffs call Dr.—Mr. Doyle Wayne Scott.

Judge Henderson: Mister. Thank you.

Wayne Scott,

Having been called as a witness by the plaintiffs was first duly sworn and examined as follows:

The Witness: I will.

The Clerk: Please have a seat.

Judge Karlton: Please state your name.

The Clerk: State and spell your full name for the Record.

The Witness: My name is Wayne Scott, W-A-Y-N-E S-C-O-T-T.

Direct examination by Ms. Norman

Ms. Norman: Good morning, Your Honors. Sara Norman from the prison law office for plaintiffs. I'm sorry. Good afternoon.

By Ms. Norman

Q. And good afternoon, Mr. Scott.

A. Good afternoon.

Q. How long did you work for the Texas Department of Criminal Justice?

* * *

[144] appointments—I'm sorry—to get inmates to offsite appointments by staff that are tasked to do that.

We ran into some issues with misclassifying offenders and put them in the wrong spot, which means that they didn't get the proper medical and mental health attention that they needed.

Q. Did overcrowding also impact your management systems?

A. Yes. From the lowest level correctional officer to the system administrator, the facility administrator to the system administrator. It was really a crisis management situation.

Every day something was breaking down at your facility because of the overcrowding and the impact it was having on your infrastructure or your timelines to get things done, and you were always in a crisis mode trying to resolve those issues.

Q. You have been to eight California prisons in the last year or so; is that right?

A. Yes, ma'am.

Q. And you toured the prisons, went to the living units, you talked to staff and prisoners and administrators?

A. Yes, I did.

Q. You've also—well, before we move on, were you surprised by the conditions that you saw in the California prisons?

A. I really was. I have been in a lot of jurisdictions over the last five years, and I haven't seen this level of overcrowding in any of those jurisdictions.

[145] Judge Karlton: I'm sorry. Let me interrupt for a moment.

You have been in a lot of prisons. You've never seen a prison with this kind of overcrowding. Do you perceive that the overcrowding, setting aside whether the overcrowding itself is undesirable, the question ultimately becomes the relationship of overcrowding to the delivery of mental and physical care. Were you able to perceive or do you perceive that there is such a relationship?

The Witness: Yes, I do.

Judge Karlton: Go ahead. I hope you'll get to the point of this trial eventually.

Ms. Norman: All right. Let's get to it directly.

By Ms. Norman

Q. In what ways did you see overcrowding in California impacting medical and mental healthcare provision?

A. Well, I did see a lot of problems with the classification system. I saw lack of staff in all of the areas that I personally visited. In talking to staff and offenders, I know that across the board there was a lot of frustration on both sides. They were, in some cases, angry because they couldn't get in in a timely fashion to see the medical doctor or the psychiatric clinician. Some of them missed their offsite specialty appointments.

Staff is frustrated also because of having to deal

* * *

[152] Q. Based on your expertise from your decades in Texas and your reviews of other correctional systems around the country and your observations and research on California, is it your opinion that

overcrowding is the primary cause of the medical and mental healthcare violations in California prisons?

A. Yes. Everything revolves around overcrowding. The deficiencies in the classification plan, the deficiencies in the unavailability of staff because they are doing other tasks associated with overcrowding problems to do onsite medical appointments or offsite medical appointments, the wear and tear on the infrastructure. I know there have been electrical outages because of the overload that the large number of offenders is causing at institutions. There's also been water problems at a number of the institutions, and I think the Governor's proclamation clearly described a lot of those issues.

So those were just some of the issues, that overcrowding creates problems for medical and mental health delivery.

Q As executive director of the Texas prison system, you oversaw on your watch the state's emergence from court orders over unconstitutional medical and mental healthcare, right?

A. I did.

Q. Could you have done that if the population remained at 200 percent capacity?

A. I'm convinced no. Once we got our population down to the [153] appropriate size for the space and infrastructure that we had at each facility, with some flexibility space for classification purposes and also for maintenance, routine maintenance, some cells were down, once we aligned all those problems, then we began to really make progress in eliminating all of the outstanding issues that we had with the court.

Q. In your opinion, is that preliminary step of population reduction, is that also essential in California in order to get a handle on the medical and mental healthcare violations?

A. Based on my experience in Texas and what I have seen, I would say yes to that.

Q. One last question, Mr. Scott. When was the last time that you testified on behalf of a prisoner or a class of prisoners?

A. I've never testified in their behalf.

Ms. Norman: Thank you.

The Witness: You're welcome.

Judge Henderson: Thank you, counsel. Cross-examination.

Mr. Mello: Do you want me to start?

Judge Henderson: Yes.

Cross-examination by Mr. Mello

By Mr. Mello

Q. Good afternoon, Mr. Scott. Paul Mello for Plata defendants.

Mr. Scott, You do not hold any degrees beyond your bachelor's degree in business administration?

[154] Judge Karlton: I'm sorry. I'm having trouble. Lift that thing up if you can.

Mr. Mello: I probably am, too.

By Mr. Mello

Q. Mr. Scott, you do not have any degrees beyond your bachelor's degree in business administration, do you?

A. No.

Q. You do not have any degrees in the medical field, correct?

A. No, I do not.

Q. You do not have any degrees in the mental health field correct?

A. No, I do not.

Q. You have never been a clinician who provided medical or mental healthcare to patients, correct?

A. That's right, I never have.

Q. Mr. Scott, you don't have any experience analyzing prison staffing or staffing ratios as they relate to medical clinicians or mental health clinicians, do you?

A. No.

Q. Mr. Scott, when you were the executive director of the Texas Department of Criminal Justice, you did not directly manage medical and mental healthcare services, correct?

A. No, I did not.

Q. Okay. When you were the executive director of the Texas Department of Criminal Justice, both medical and mental health [155] services were run by a medical director who was a physician, correct?

A. That's correct. I supervised her administratively, but I did not deal in any clinical decisions at all.

Q. And, in fact, that medical director actually reported to a deputy of yours, correct?

A. That's correct.

Q. Mr. Scott, you were never qualified to be the Medical Director of the Texas system, were you?

A. Could you ask that again?

Q. Sure.

Were you ever qualified in your mind to be the director of the medical system in that position that reported to you? Were you ever qualified to do that?

A. No. It called for a physician.

Q. Okay. I believe you testified or spoke about in one of your depositions or in your report that—your reports that you performed analysis of several states regarding how many correctional officers were needed for medical exports—pardon me—escorts to transfer inmates to both onsite and offsite medical services, correct?

A. That's correct.

Q. Okay. And you did that in Florida?

A. Yes.

Q. And you did that in Oklahoma?

[156] A. Yes.

Q. And you did it in Kentucky?

A. Yes.

Q. Did you also did it in Indiana?

A. Yes.

Q. And New Mexico?

A. Yes.

Q. And Puerto Rico?

A. Yes.

Q. Okay. When you did that type of analysis in Florida in 2006, you visited eight institutions, spending two full days at each institution, correct?

A. That's right.

Q. In this case you've offered opinions regarding the effects of overcrowding on medical and mental healthcare across California's 33 prisons, correct?

A. Yes, I have.

Q. Okay. In forming those opinions, did you visit each one of California's 33 prisons?

A. No, I visited eight.

Q. You visited eight, correct?

A. I did, yes.

Q. And you visited five last year, correct?

A. It was four and four.

Q. Four and four?

[157] A. Yes.

Q. I'm sorry.

So in 2007, which four institutions did you visit?

A. CIM, Avenal, Valley State and San Quentin.

Q. Did you spend two days at each one of those institutions in 2007?

A. No, I did not.

Q. In fact, you spent less than a full day at each of those institutions, correct?

A. I think I spent a full day at CIM, but that was the only one, yes, sir.

Q. Approximately how long did you spend at Valley State?

A. A half a day.

Q. Okay. Did you also spend a half day at Avenal?

A. Avenal was very large. It was a little longer. Five or six hours probably.

Q. And how about at San Quentin?

A. Five or six, seven hours. It's pretty large also.

Q. Okay. Mr. Scott, did you prepare the first draft of either one of your reports in this case?

A. Did I prepare the draft myself? No.

Q. Okay. Who prepared the first draft of your reports?

A. Ms. Norman.

Q. I'm sorry?

A. Ms. Norman.

[158] Q. Plaintiffs' counsel?

A. Yes.

Q. In your first report, your November 2007 report, at page 44, paragraph 79—put it up on the screen. I also have a hard copy if that's easier for you, but I believe it's right in front of you.

(Document Displayed.)

By Mr. Mello

Q. You said in paragraph 79:

> "It is impossible under current conditions to provide adequate medical and mental Healthcare to California's prisoners." Do you see that?

A. Yes, I do.

Q. And you—at the time you issued that statement, that was based upon visits at four institutions, correct?

A. Yes.

Q. Okay. Next we are going to go to paragraph 59 of your report on approximately page 33. In that section of your report you wrote that:

> "An officer alone with several hundred inmates is unlikely, for example, to perform emergency first aid or CPR. It is simply unsafe to do so with no backup when prisoners could easily simulate an emergency as a consequence—[159] as a diversion. This inability to perform basic lifesaving functions could have potentially devastating consequences on the life and health of a prisoner undergoing a medical or mental health emergency."

Do you remember that being in your report?

A. Yes.

Q. Okay. At the time this was written, you were not aware of even a single incident where an inmate in any of California's prisons was denied medical care due to the lack of custodial staff, were you?

A. No. That statement was based upon my experience in Texas when we were undergoing the overcrowding there.

Q. It wasn't based on anything you learned during your tours or investigation in this matter?

A. No. I would say, though, that it's very likely that the same situation could occur as it occurred in Texas more than once.

Q. But you can't tell me one inmate who had such a circumstance, correct?

A. Not from personal knowledge, no.

Q. Okay. In forming your opinions in this case, did you rely on the receiver's analysis of CDCR death reviews for 2006 or 2007? The 2006 report is defendants' exhibit 1107, and we'll put up the front page if possible.

[160] (Document Displayed.)

By Mr. Mello

Q. I don't believe you reviewed this prior to drafting either one of your reports; Is that correct?

A. I did not.

Q. Okay. And let's pull up the 2008—I mean, the 2007 review. I'm sorry. It's 1233, defendants' 1233.

(Document Displayed.)

By Mr. Mello

Q. Did you review this document before arriving at any of your opinions in this case?

A. No.

Q Okay. At the time you wrote your statement in paragraph 59 of your November 2007 report that was just quoted earlier by me, you were not aware of the alleged 18 preventable deaths identified in the 2006 report, were you?

A. No.

Q. And you were not aware if none of those 18 preventable deaths were the result of poor response to emergency or man-down situations, were you?

A. No.

Q. And, in fact, and I believe you've already testified to this, you did not base your statement just quoted on any data about incidents in California's prisons, did you?

A. Well, I saw, obviously saw a lot of the individual cases [161] that were presented in the receiver's reports that I had reviewed prior to giving both depositions. So I'm sure that had some impact on my decision making.

Q. But you're not aware of the fact of those 18 deaths, preventable deaths or allegedly preventable deaths in 2006, the receiver did not report that any of them were the result of poor response to emergency or man-down situations?

A. No, I didn't review that report.

Q. Okay. Do you know the state of medical or mental healthcare delivery at Avenal State Prison as of August 2008?

A. That's a broad question. Can you—that's a broad question. Can you clarify it a little bit?

Q. When was the last time you were at Avenal State Prison?

A. Late October, early November of 2007.

Q. Have you reviewed any documents relating to Avenal State Prison since that time?

A. Only in regards to what has been in the receiver's reports or any expert reports I reviewed.

Q. As you sit here today, can you tell me specifically about the quality of care at Avenal State Prison as of August 2008?

A. The quality of care, no, that was not my charge. I didn't look at quality of care issues.

Q. When I use the term "quality of care," I mean whether medical and mental healthcare rose to constitutional levels. Is that your understanding, too?

[162] A. Again, I'm not exactly sure what you're saying, but I didn't look at quality of care issues.

Q. Okay.

A. I looked at impediments to delivery or access to the care only.

Q. And you don't feel qualified to testify about the quality of medical or mental healthcare, correct?

A. Well, only as a layman who has actually supervised as a warden mental health in a hospital at my institution, and as the executive director of an agency, I had to oversee constitutional levels of care in both of those areas.

Q. Have you been-- when was the last time you were at CIM or California Institute of Men?

A. At that same time period.

Q. Do you know the quality of medical or mental healthcare at CIM as of August 2008?

A. No. Again, I didn't look at quality of care issues.

Q. Okay. Do you know the number of custodial staff at Avenal State Prison as of August 2008?

A. August 2008, No, I don't.

Q. Did you know the number of custodial staff as of any time in 2007 at Avenal State Prison?

A. Did I know? Yes, it was in my notes.

Q. Was it reflected in your report?

A. I don't remember if I put it in the report or not.

[163] Q. If I represented to you that I did not believe those numbers were in your report, would you be surprised by that?

A. I don't remember, so I would take your word for it. I do remember taking the notes.

Q. I don't know if I'd do that.

A. I do remember specifically asking the question at each institution and making notations in my handwritten notes that I kept.

Q. Do you know the number of correctional officers at valley state prison for women as of August 2008?

A. No, I don't.

Q. Okay. Do you know the number of medical and mental health staff at Avenal or any of the prisons you visited in 2007 as of August 2008?

A. No, I didn't look at medical or clinical staff at all.

Q. Okay. And, again, I'm guessing I know the answer here, but you do not know the state of medical or mental health delivery at California State Prison San Quentin as of August 2008 either, do you?

A. I think you asked that question differently than you did in the past. You used the word "delivery" that time.

Q. I did use the word "delivery." do you know the status of medical delivery at San Quentin as of August 2008?

A. As of only what I have seen in the receiver's reports.

Q. And you don't know the status of mental healthcare delivery [164] At San Quentin as of August 2008 either, correct?

A. Again, it would be what I read in the receiver's reports.

Q. And I assume you do not know the number of custodial staff at San Quentin as of August 2008, correct?

A. No, I don't.

Q. You toured Folsom prison in June 2008, correct?

A. Yes.

Q. So in 2008, you toured Folsom. Which three other prisons did you tour in 2008?

A. Sacramento, Solano, and the last one escapes me.

Q. The last one does?

A. Folsom, Sacramento, Solano. Oh, DVI.

Q. Okay. When you toured Folsom in June 2008, neither the medical staff nor the warden told you anything about the status of delivery of medical or mental healthcare at Folsom, did they?

A. Not that I recall.

Q. Okay. Do you know the—did you know the number of custodial staff at Folsom prison after June 2008?

A. After June—No, I don't.

Q. How about in June 2008?

A. When I did my tour, I asked the question and took the notes.

Q. And did you—strike that.

However, your report did not indicate the number of correctional staff at Folsom prison, correct?

A. Again, I don't recall.

[165] Q. When you toured Cal State Prison Solano in June 2008, neither the medical staff, nor the warden told you anything about the status of delivery of medical or mental healthcare at Solano, did they?

A. I didn't see the warden.

Q. Did anybody—did the medical or mental health staff tell you the status of delivery of medical or mental healthcare at Solano during your June tour?

A. No.

Q. And, again, did you know the number of correctional staff at Solano in June 2008?

A. I did on the day of the tour.

Q. However, you did not place those numbers in your report, correct?

A. I'll take your word for it. If you say they are not there, they're not there.

Q. Okay. And do you know the number of correctional staff since June 2008 at Solano?

A. No, I don't.

Q. Okay. You toured DVI in June 2008?

A. I did.

Q. And you did not learn of any specific delays in the delivery of medical or mental healthcare when you toured that facility, correct?

A. No, that's not true.

[166] Q. Okay. What were you told, or what did you learn?

A. Okay. By both offenders and staff, it's a reception center, and there were a large body of offenders waiting to get through the reception and diagnostic process. And in talking with both the reception offenders and the non-reception offenders that were permanently assigned there, one, I learned from the reception offenders that they were—the process was dragging out very long, and that they were anxious to be classified and move along to their permanent level of assignment.

And, secondly, from the permanent offenders there, permanently assigned offenders there, they were frustrated because they couldn't get in for their medical appointment because all the processing was taking place and there was not time for them to receive their regular appointments.

Q. Did any of those individuals tell you how long the delays were?

A. They did, and the answers varied from weeks to months.

Q. Okay. Did any of the individuals that you spoke to who spoke of delays in access to medical or mental healthcare tell you that they suffered an adverse medical consequence as a result of those delays?

A. No, but I didn't ask that question.

Q. And nobody offered that to you either?

A. No.

Q. Do you know the number of custodial staff at DVI since you [167] last visited there?

A. No, I do not.

Q. So you don't know it as of the end of August 2008, correct?

A. No.

Q. That's correct?

A. That's correct.

Q. You toured Cal State or Cal—the prison at Sacramento, correct?

A. Yes.

Q. In June 2008?

A. yes.

Q. And neither the medical staff nor the warden told you anything about the status of delivery of medical or mental healthcare at Sac, did they?

A. No.

Q. That's correct?

A. That is correct.

Q. When you toured Sac in June 2008, was it overcrowded, in your opinion?

A. Yes.

Q. When you toured—when you toured Sac in June 2008, you concluded that the correctional treatment center at the prison was in excellent condition, didn't you?

A. Sanitation-wise, yes.

Q. What do you mean by that?

* * *

[170] that. I only looked at impediments to the delivery of care.

Q. So the answer is you are not aware of one inmate who suffered an adverse consequence, correct?

A. I think I answered that I did not.

Q. Okay. You do not even know of one instance where an inmate became ill due to chronic idleness, do you?

A. No.

Q. You do not know of even one instance where an inmate was denied needed medical care due to a reduced availability of programming or recreation space, do you?

[171] A. No.

Q. You do not know of even one instance where an inmate was denied medical care due to chronic idleness, do you?

A. No.

Judge Henderson: Excuse me, Mr. Mello. I just received a note that our reporter's fingers are getting tired. Let's find a convenient place to take a 15-minute recess.

Mr. Mello: Sure. Couple more questions.

By Mr. Mello

Q. On page 3, paragraph 5 of your August 2008 report, you opined that, quote, "it is inhumane to warehouse prisoners two to a cell under such conditions," end quote; do you see that?

A. Yes.

Q. You do not know of even one instance where an inmate became sick due to double celling, do you?

[171] A. No.

Q. You do not know of even one instance where an inmate was denied medical care due to double celling, do you?

A. No. From personal knowledge, no.

Mr. Mello: We can break.

Judge Henderson: Okay. Court is adjourned for 15 minutes.

(Recess taken.)

The Clerk: Please come to order. Court is in session.

Please be seated.

Judge Henderson: Okay. You may resume when you're ready, counsel.

Mr. Mello: Thank you.

By Mr. Mello:

Q. Mr. Scott, I'm going to ask you questions about paragraph seven of your August, 2008 report.

In that report at paragraph seven you opine that Folsom's building five had solid metal doors, door cells making, quote:

> "Direct supervision extremely difficult," end quote and making staff, quote:
>
> "Even less likely to be able to respond appropriately to medical and mental healthcare emergencies," end quote.

* * *

[176] of fear of anonymity or mistrust by custody staff, do you?

A. Not in California. I saw a great deal of this in Texas when we were very overcrowded such as California is now.

Q. When you formed your opinions you did not know the inmate to mental healthcare clinical staff ratio in CDCR's prisons, did you?

A. I did not look at that.

Q. And when you formed your opinions you did not know the staffing levels for physicians in California's prisons, did you?

A. No, I haven't looked at that.

Q. And when you formed your opinions in this case, you did not know the staffing levels for registered nurses at California's prisons, either, correct?

A. No. I mean, I can tell you based on my experience as an executive director that ran an agency almost as large as California I had the responsibility of making sure that constitutional levels of mental health and medical care were given, and I kept—I understand that it takes clinicians and it takes nurses and it takes physicians to do that.

So in that regard I think I can make somewhat of an opinion.

Q. Okay.

Mr. Mello: And I'd move to strike that as non-responsive.

* * *

[180] healthcare delivery, correct?

A. Let me see if I understand. Did you say—It was garbled. Did you say that the lack of custody staff was only one factor?

Q. Yes.

A. Yes, I would agree with that.

Q. And it's not the single most important factor, is it?

A. No, overcrowding is the single most important factor.

Q. More important than doctors?

A. Can't really do anything until you get your overcrowding down. That's my opinion.

Q. And that's based upon your experience in Texas?

A. Yes.

Q. And that's based upon your review of or visits to 8 of the 33 prisons in California?

A. Yes, and my review of the receiver's report, the special master's reports, the other experts' reports.

Q. And your discussions with plaintiffs' counsel?

A. I don't know that they have opined on that to me or asked me to adopt their opinion.

Q. And you testified briefly about your experience getting out from under the court orders in Texas.

A. Yes.

Q. And that involved building new prisons, correct?

A. Yes.

* * *

VOL. 2

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 11/19/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings

San Francisco, California
Tuesday, November 18, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Katherine Wyatt, CSR 9866, RMR
Official Court Reporters, U.S. District Court

* * * *

[199] Proceedings; Wednesday, November 19, 2008

The Clerk: Please state your appearances, counsel.

Mr. Specter: Donald Specter, Alison Hardy for the plaintiffs.

Mr. Bien: Michael Bien for the Coleman plaintiffs.

Judge Karlton: You don't need to go through all that. Just people announce when they are speaking.

Ms. Leonard: Natalie Leonard, Carroll, Burdick & Mcdonough.

Judge Henderson: We will assume everyone is here. Why don't we get going?

Judge Reinhardt: Could we do yesterday over today? Now I can hear.

Judge Henderson: you may call your next witness, counsel.

Mr. Specter: Thank you, Your Honor. Plaintiffs call Dr. Jeffrey Beard.

Judge Karlton: You violated the first rule. You didn't say who you were.

Mr. Specter: You are right. I sinned again. Donald Specter for the plaintiffs.

Jeffrey A. Beard, PH.D.

Having been called as a witness by the plaintiffs was first duly sworn and examined as follows:

[200] The Witness: I do.

The Clerk: Spell and state your full name for the record.

The Witness: Jeffrey A Beard. J-E-F-F-R-E-Y, middle initial A., B-E-A-R-D.

Mr. Specter: Thank you.

Your Honors, just a brief note of introduction, Dr. Beard is not a retained witness. We did not file a report for him, therefore, I'm going to go into some more detail about his background and experience than we have been with the rest of the witnesses.

Judge Henderson: Fine. Okay.

Direct examination by Mr. Specter

By Mr. Specter

Q. Dr. Beard, Where are you currently employed?

A. I'm currently secretary of the Pennsylvania Department of Corrections.

Q. Why do we call you doctor?

A. Because I have a PhD. from Penn State University.

Q. In what discipline?

A. Counseling.

Q. And are you a licensed psychologist?

A. I am.

Q. how long have you been the secretary of the Pennsylvania Department of Corrections?

* * *

[202] A. Yes. As the deputy superintendent for treatment at the state correctional institution at rockview, one of my responsibilities was to oversee not only the healthcare department, but also the psychology department, mental healthcare, dental care

and things like that. Then, of course, as warden of two institutions, I was ultimately responsible for the health and mental healthcare in those facilities. Then as a deputy secretary and now as secretary, I'm also ultimately responsible at different levels for those care—for those types of care.

Q. In your current position can you please describe what activities you pursue in terms of healthcare?

A. In my current position?

Q. Yes.

A. Well, we contract for our medical care and for our mental health care, so I'm regularly involved in reviewing the RFP's and responses to RFP's that go out to ensure we are providing comprehensive mental health and medical care to the inmate population.

Q. So do you practice as a psychologist?

A. I don't. I haven't practiced since about 4-1/2 years into my stay with the Pennsylvania Department of Corrections, and I've actually—my license is in an inactive status right now because of that.

Q. Nevertheless, do you consider yourself an expert in any [203] aspect of the delivery of healthcare to prisoners?

A. Well, I certainly consider myself an expert in the various things that are required to make sure that we're delivering constitutionally adequate healthcare to the inmate population. I'm not a physician, so when it gets to individual clinical care of an individual, that's not my area of expertise, certainly. But I do know and have—through my long years of experience do know the various elements that are required to provide proper healthcare and proper mental healthcare to the inmate population.

Q. And could you briefly summarize your understanding of those elements, please?

A. Well, when you are talking about healthcare, first of all, you have people coming into your system. You have to identify the various medical problems and medical needs that those individuals have. You have to have primary care physicians working for you in adequate numbers so they can review not only the incoming people, but on an ongoing basis take care of sick call and things like that.

You have to have specialists on contract so when a individual has a dermatological problem or orthopedic problem, you can refer them to some specialist for care. You have to have contracts with hospitals so that if an individual needs to go out for some kind of operation or whatever, that's available. You need to have tertiary care hospitals for people who need [204] higher levels of care. You have to have a proper medical records system in place so that you can follow the inmate, you can provide continuity of care, and that if they move from one institution to another institution, the people are aware of what they need. You have to have a medication system in place so that those individuals who need medication receive medication and receive it in a timely manner. You have to have policies in place that see that all of this care is provided in an appropriate manner to the inmate population.

Q. Do you have to have any quality assurance programs?

A. Certainly. I did miss that. In our state we do have a very extensive quality assurance program there. That's really a key—it's a key no matter what you do, whether you're providing mental health care or whether you're providing medical care or providing programs, because if you don't have that in place, you are not able to see where you are developing problems, maybe where you are not doing what you should be doing and where you need to make changes.

Q. What's the current population of the Pennsylvania Department of Corrections?

A. We currently have just a little over 48,000 inmates.

Q. How many prisons are those inmates housed in?

A. They're housed in 26 prisons and a boot camp.

Q. Are you housing prisoners over design capacity in Pennsylvania?

[205] A. We don't use the term "design capacity." We use "operable capacity." We look at each one of our facilities and see what those facilities—not only space-wise but job-wise, program-wise, receiver-wise, what they can handle, and we determine an operable capacity. We're currently operating about 5,000 inmates over that operable capacity in our system.

Q. And does that concern you in any way in terms of the operation of your system?

A. It certainly concerns me. I think it's not high enough yet that we can't provide the basic care that we need to provide to the inmates within the institution, and we monitor that very closely. But any time that you're running over capacity, you have more inmates who don't have jobs that are idle, you have more possibilities of having problems within an institution. It increases the level of risk even if you are only somewhat over capacity.

So, you know, my hope and one of the directions I'm taking in my state is try to get us down to a point where we get closer to that operable capacity.

Q. So what have you done to get closer to the operable capacity?

A. Well, one of the things that we did is we recently passed some legislation that has a — really what is termed an earned time provision in it to allow certain nonviolent offenders to get out earlier, and we have another piece of that, a state

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[209] with submarines back in World War II where we didn't have enough beds for people, so two people would share the same bed. That's not something that we do or have ever done in Pennsylvania, despite the fact that I read in one of the expert's reports that we did that. I don't know where that individual got that.

Q. Now, you became the warden of an institution called Camp Hill; is that correct?

A. Yes.

Q. Can you describe the circumstances under which you became the warden of that institution?

A. Well, that was back in 1989 at a time when our system was quite overcrowded. We were at about 150 or 160 percent of our capacity. Most of our institutions were having difficulties operating. Camp Hill was particularly overcrowded, and they had two very serious riots within three days. A lot of people were hurt. A lot of people were injured. And it was some ten days after that riot that I was assigned to take over that facility.

Q. And do you attribute the riots in any way to the overcrowding?

A. Absolutely. There was no question that we had riots, actually, not only at Camp Hill, but at rockview and at Huntington, two of our other prisons, in the same time period. And there's absolutely no question in my mind that having too many inmates in those facilities, making it difficult to manage those facilities safely, led to those riots.

[210] Q. Okay. And did the level of overcrowding that you experienced in Pennsylvania during that time affect the department's ability to provide adequate healthcare to prisoners?

A. You know, when I look back, the answer is yes. You know, when you're there and you're doing something at a particular time, you think you are doing a good job, but we actually had a class action lawsuit put against us in 1990, the Austin suit, where the plaintiffs were saying that we really weren't providing adequate mental health and medical care.

When I look back on what they were requesting and what we finally agreed to do, because we settled that suit, there's no question that the care we provide today is far better than what we were providing back at that time.

Q. Did the state of California ever ask you to help them in relation to its prison system?

A. I was asked to be a member of the expert panel to take a look at designing a road map to programming within the state because I understood that they wanted to get more programs in their system to try to reduce recidivism. So I was part of that panel.

Q. When was that?

A. It was back a couple of years ago.

Q. 2006, end of 2006?

A. That would be about right.

[211] Judge Henderson: Excuse me. Let me go back a minute. I may have missed it, but what was the level of overcrowding at the time of the riots you just referred to; do you recall?

The Witness: We were at 150 to 160 percent of our capacity at that time, Your Honor.

By Mr. Specter

Q. During the course of your participation as a member of what has been referred to as the expert panel, did you—were you provided with information about the California prison system?

A. Yes. We were provided with pretty much anything we asked for, data, information, reports. We also had some presentations by members of their staff, and members of their staff were part of the expert panel.

Q. And the presentations included from the secretary of the department?

A. The Secretary—secretary Tilton did attend the first meeting that we had as an expert panel, yes.

Q. And they provided you information on how overcrowded they were and any information that you needed to perform your task; is that right?

A. Yes, that's correct.

Q. So you understand that California is close to 200 percent of design capacity; is that right?

A. Yes. At the time that we were doing that back in 2006, I [212] think they were over 200 percent, and I think now they're down around 190-some percent of capacity.

Judge Henderson: Let me interrupt again.

Mr. Specter: Sure.

Judge Henderson: You talk in Pennsylvania in terms of operable capacity and we're now talking about design. Are those apples and oranges, or tell us how we can—

The Witness: Well, I think, Your Honor, probably more comparable than they would be today, because back at that time we were still looking at single celling all of our inmates, and we were looking at design capacity. Since then we have built facilities for double celling, and we have gone more to double celling, and that's why we went to this operable capacity thing.

We also spent millions of dollars upgrading the infrastructure at older institutions so that we were capable of putting more inmates than that institution was originally designed for. So that's why it's no longer appropriate for us to talk about design capacity.

But the 150 or 60 percent I mentioned was based on design capacity at that time.

Judge Henderson: Okay.

By Mr. Specter

Q. How big are the prisons in Pennsylvania in terms of the size, of the number of prisoners that are housed there?

[213] A. We like to run our prisons at about 2,000 inmates. We have two larger prisons, the one runs in around 3,200. The other one runs around 3,300.

Those are our largest two prisons. Everything else is 2,000 or less. I should say 2,500 or less.

We found that as prisons get much higher than 3,000, 3,500, they become very, very difficult for one management team to operate.

We did have a prison, Graterford, that was severely overcrowded back at the time I talked about in the late '80's and early '90's. That prison, which was originally designed for 2,000 inmates was running close to 4,100 inmates. It was actually over a hundred—two hundred percent of capacity. That was our worst prison, our most difficult prison. High rates of assaults and incidents in that prison, very difficult to manage.

We've brought that down to about 3,200. Now we are able to manage that prison. But that's sort of like hitting the upper limits of where I would want to run a prison about, you know, 3,000 to 3,500. I wouldn't want to go over that.

Q. So during the course of your participation in the expert panel, you became aware of the size of the California prisons; is that correct?

A. Yes, I did.

Q. And what's your understanding of how large they are?

A. Well, my understanding is some of the prisons run upwards of [214] 7,000 or more inmates.

Q. What's your opinion about an ability to manage an institution which is that overcrowded and that large?

A. My opinion is it is impossible to really do a good job with prisons that large. And that comes from experience of running a prison, the Camp Hill Prison. Before I left there, got up to between—I think we got up to about 3,300 inmates, and that was starting to become difficult at that time to manage that prison. And so I would say I wouldn't want to have to run a prison that was 7,000 inmates.

Judge Karlton: You just said it's impossible to run a prison and do a good job. I'm not sure I know what a good job is in terms of prison. Would you give me an idea, if you can—

The Witness: Sure.

Judge Karlton:— Of what kinds of things you can't Do?

The Witness: Well, one of the big things is—the key, in my opinion, to running prisons is the warden and his team within the prison. And the key to them doing a good job is going out and getting around the institution, talking to the inmates, talking to the staff, taking care of the little problems that exist within prisons, seeing that problems don't become big problems. And the bigger the prison gets, the more difficult it is for that management team to really successfully go out there and take care of those smaller [215] problems and prevent them from getting bigger.

I've done a lot of work studying prison disturbances and riots around the country, looked at some of the things within my own state, and what you find is when you have problems like that, it's one of two things. Either the prisons are so large that the team can't handle that prison, or you have a poor management team.

So you can have a smaller prison, 2,000 inmates, and if you have a poor warden and poor deputies that never get out, never talk to anybody, you can have problems within that prison. So, from my experience, that's the biggest thing of helping you manage it.

There's a lot of other things about whether you have the capability within the prison. You know, if you take a prison that's built for 4,000 inmates and you put 7,000 inmates in there, that is even a complicating problem then. Not only is it so huge that your management team can't do a good job, but all your services start suffering within that prison. You know, your ability to provide, say, proper sanitation, you know, because your showers, they're overused, every day people are going in the showers and out. You don't have time to clean the showers appropriately because they're in use all the time. Or the laundry services, you are not able to clean the clothes and get the clothes back to the inmates. You know, all of these things start suffering when you get so overcrowded and so big [216] and there's all this day-to-day activity that goes on within a prison.

You know, I think people sometimes don't understand the complexity of running these prisons. This is like running a city. I mean, we have to provide water. We have to provide sewage. We have to provide jobs to people. We have to provide, you know, the laundry services. We have to provide food.

When you overcrowd prisons, things get used more, things break down a lot more than they would that you are constantly running out there fixing things. Your infrastructure suffers. All of these things occur as you put more and more inmates in a facility that was designed for less inmates.

Judge Karlton: Particularly in terms of what this lawsuit is about, is it your view that if the institution runs more than 3,200 people, plus or minus, I understand, there is effects upon the provision of medical and mental health care, and, if so, how?

The Witness: I guess what I would say with that is it is possible to have larger prisons and to provide proper medical and mental health care in those prisons, but that's assuming that those prisons were designed for the number of inmates that you have in there. That assumes that you have enough space in those prisons to—you know, to provide whatever the care needs to be done, to interview the inmates, to see the inmates. That makes those kinds of assumptions.

[217] And it also assumes that the large size of the prison has not seriously affected your ability to run that prison safely, which can happen. Again, as that management team has more difficulty managing these larger numbers of people, then your prison could become more unsafe. There's more idleness in the prison and things—you know, it could make it then difficult—for instance, if you rely a lot on lockdowns to control your prison, how are people getting to their mental healthcare? How are they getting to their medical care? How are they getting their medication appropriately? Those kinds of things do get impacted.

So I guess, to answer your question, it's possible to do it, but it becomes that much more difficult even if you have the resources and space because of the other things that start occurring that start interfering with the ability to provide this kind of care.

By Mr. Specter

Q. To elaborate on the judge's question for a bit, you're aware that California's prisons, like you said, are close to 200 percent—between 190 to 200 percent of capacity, and with that level of overcrowding, is it possible to provide adequate healthcare services to prisoners?

A. Well, from everything that I have seen, the reports that I've looked at and reviewed from the various experts and other people, I don't see how California could, as it currently sits [218] with the number of inmates they have, deliver proper mental health or medical care, because their prisons are unsafe.

And when I talk about unsafe, you look at the number of incidents that they have. You look at their assault rates within the prison. The assault rates are going up, at least up through 2006. That's the only reports I was able to see off their website. Their incident rates are going up.

And then I sort of compared it to our assault rates. It's like 2-1/2 times, if you bring it down comparison-wise size of the institution. Their homicide rate is extremely high. You look between 2000 and 2006, and the average is 11.34 homicides within their system. If you applied that to my system, we would have three a year. During that period of time, we've had three over that period of time, not three a year. Suicide rates, from what I've read and from the numbers of that I've seen, they're just about twice what the national average is.

All of those things show me that you have a system that isn't safe. They rely largely on lockdowns to control their system, and they have to do that. I mean, you can't have people running around hurting people. But, you know, I think in 2006, they had 449 lockdowns, which averaged 12 days a lockdown. And they had 20 or so of those lockdowns that were over 60 days. Those things impact upon your ability to properly deliver any service within an institution, including mental health and medical services.

[219] Q. and you mentioned a lot of factors that go into the delivery of care and the operation of the prisons. In terms of the most important, which one is most important in your mind?

A. Most important?

Q. In terms of inhibiting the ability of—

A. I think from everything that I've seen and all of the reports and information that I've seen, I think the biggest inhibiting factor right now in California being able to deliver appropriate mental health and medical care is the severe overcrowding of their system.

Q. And do you believe that they are going to be able —based on your experience in Pennsylvania and the information you've reviewed, do you believe they'll be able to provide adequate care without reducing the population to a manageable level?

A. The only way that I could see that that could occur is if we're willing—or if they're willing to wait for many years, spend huge amounts of money. And I'm not even sure that that would get them there, because, you know, over the last 20 years they've spent billions of dollars on construction and building, and they haven't really been able to dig their way out of the hole.

So I think it would be very difficult to just, you know, say, rely on construction alone to deal with this problem. I think they have to find some way to fairly substantially reduce the inmate population.

[220] Q. And in terms of your experience of trying to build your way out of the problem, can you explain

why you—why you don't think that is a timely response to the issues?

A Well, the reason I don't think it's a timely response is when I look at what's happened in my state, and even some other states around the country, people aren't really willing to put the kinds of money into that that needs to be put in. So we'll have approved projects to build a new prison or to build five new prisons, and it's very slow coming because even though the project is approved, somebody has to release the money for design and somebody has to release the money for construction.

So in my experience, you know, states want to spend as little as they can on the prison systems because there's so many other competing things out there. I mean, you know, you have healthcare and education, the elderly and all these other important things to spend money on. So they tend to only spend what they absolutely have to, and that's why I think they're never able to build their way out, because they never really sit down and say, okay, we got to build 20 new prisons, or whatever it is.

Q. What about issues of siting in the community?

A. You know, I mean, I don't know if by that you mean the AB 900.

Q. No. I mean the ability of communities to accept prisons in their neighborhoods.

[221] A. Okay. Well, there's no question that that's a problem. We had that problem in Pennsylvania. You have that problem around the country.

I had—excellent example. We had an old prison, over a hundred years old. We wanted to close it. We wanted to build a new prison near it. It was in the

Pittsburgh area. We couldn't find a site nearby. We kept getting run out of town; there's a school too close, or whatever. We ended up having to build that in some more rural area, far removed from where we wanted to build it.

And I think you are going to find the same thing here, particularly, you know, if you want to build a lot of reentry facilities. You should build those reentry facilities near your major metropolitan areas where most of your inmates come from. I think it's going to be very, very difficult to site those facilities close to those areas.

Q. Couldn't the problem—could the problem of the lack of healthcare be caused by the culture of the prison system in terms of the custodial interference with the delivery of care rather than overcrowding?

A. Well, from what I can see, you know, the culture is a problem. There is no question about that. But you got to look back where did this culture come from. And at least from what I've read, California back in the early 1970's was one of the most progressive systems in this nation, and they went from [222] being one of the most progressive systems to being one of the most overcrowded systems in this nation, and they did that because of all the laws, and the drug laws, and all the things, the mandatories, and the two strikes, and three strikes, and everything else that drives that population.

Now, if you fix the crowding problem, that doesn't fix all the problem. You do have to deal with the culture, but you have to realize that the culture grew out of the overcrowding.

If I'm running an institution, if I'm a warden of an institution, my first job is to see that that institution runs safely for my staff and for my inmates, and if it's not running safely, I've got to take the steps that I've got to take.

And from what I can see, California, they have inmates coming in, so they have to have bed space. They have to find a place to put people. They are having a difficult time controlling their prisons, so they have to take a strong custodial approach to it. They have to rely on the lockdowns. They have to rely on guns, gas, those kinds of things, to control the prisons so they're safe for the staff and for their inmates.

If you try to change that culture, you can't. You can't change the culture until you reduce the population and can make the institution safe. But then you do have to deal with the culture and try to change that as well.

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[230] By Mr. Specter

Q. Dr. Beard, You have been a corrections professional for 36 years. Have you ever testified in a case—in a plaintiff's case?

A. On what?

Q. For the plaintiffs.

A. No.

Q. And you're here as a non-retained expert. That means you are not being paid for your testimony, correct?

A. That's correct.

Q. Could you explain to the court why you are—you took the time out from running your system to come to California to testify today?

A. Well, it's sort of--I guess its a complex answer. Maybe it's not a complex answer.

I have given 36 years to—in trying to see that we run a safe system in Pennsylvania, safe for inmates, safe for staff, and that we provide the proper care, whatever that care may be, whether it's medical, mental health, whatever the care is, to the inmate population.

And when I came out here to California, I met many very good people that worked for the California Department of Corrections, people who want to do the right thing, people who want to move ahead. And I began looking at all these reports over the last 20 years, the Little Hoover Commission, the [231] independent review panel reports, and I see that California has this problem that has just been going on and on and on for years and years and years, and nobody seems to be willing to step up to the plate and fix the problem. And as a result of that, they have hugely overcrowding prisons. They have—they're unable to provide proper care in some cases, mental health care and medical care within those prisons.

And, more importantly, to me, as a former warden is the prisons aren't safe. They aren't safe for the staff and the inmates, and they have to rely on all these different unusual kind of things to control those prisons.

I guess if there's anything that I can do to help see that California moves in a direction that will allow the people that work within the California Department of Corrections to start running a good, safe system and providing the proper care they should be providing to those people that are put into our charge and to be enabled to do the programs for the inmates so when those inmates are released, the public safety isn't adversely affected. I suppose if I can do anything to help in that, that's why I'm here today.

Q. Thank you. Couple more questions.

You mentioned you've reviewed various reports from Dr. Shansky, the Special Master, the Receiver, Ms. Woodford, Mr. Scott and the like. Did you—are those type of reports that you would generally receive as secretary?

[232] A. Yes. As secretary of corrections in a relatively large state, you can't be everywhere all the time, and so you have to rely on data that you get from the institutions. You have to rely on reports that you get from your superintendents or, in my case, I also have my regional deputies that go out with teams on a regular basis to review what's going on, to tell me what's going on in my prisons, and I visit them myself as well, but I can't be there all the time.

So I rely largely on those reports, and what I read in these expert reports that you mention, that's the kind of information that, if I got those kinds of things, I would be very, very concerned about.

I know Wayne Scott. I know Jeanne Woodford. These people are consummate professionals. They have been in the business for over 30 years. The kinds of stuff they write in their reports are the very kinds of things I could see me writing if I was walking through the same institutions and seeing the same things.

Q. If those reports referred—instead of referring to the Department of Corrections in California, they referred to the Pennsylvania Department of Corrections, what would be your reaction?

A. My reaction would be that I would not be sitting here today; I would be back in Pennsylvania fixing whatever problems I needed to fix.

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[234] A. I didn't know it at that time, no.

Q. Do you know it now?

A. The physician-to-inmate ratio?

Q. Yes.

A. Our primary care physicians and Pa's is about 3.14 per thousand.

Q. Do you know what the rate is for mental health clinicians?

A. For psychiatrists, 1.45 per thousand.

Q. Psychiatrists?

A. Pardon?

Q. You said for psychologists?

A. Psychiatrists.

Q. I'm sorry.

A. We have far more psychologists, and I don't have the ratio of the psychologists, but most of our institutions have six, seven. Depends on the size or more psychologists. Psychiatrists is 1.45 per thousand.

Q. You've never evaluated the delivery of medical and mental health care in California's prisons, correct?

A. I have not personally visited any of the prisons to evaluate that care. I've only reviewed the reports that we mentioned earlier.

Q. Including trial affidavits of plaintiffs' experts in this case, correct?

A. Pardon?

[235] Q. Including the trial affidavits of plaintiffs' experts in this case, correct? When you say "the reports of the experts," you are referring to plaintiffs' experts, correct?

A. Yes. I have—you mean I didn't review the defendants' experts?

Q. I'm just asking if you reviewed plaintiffs' expert reports, correct?

A. And defendants' experts reports.

Q. And during your testimony, you indicated those were the types of things you would review if you were—those are the types of items that you review in your position in Pennsylvania, correct?

A. That's one of the kinds of things that I would be reviewing. Inputs from my doctor, we have doctors that work for me that oversee the healthcare. I have a psychiatrist that works for me. They provide me reports. So they may not be exactly like these reports, but they're similar. They would provide me a report if we have a death somewhere, whether that death was an appropriate death or not, that kind of thing.

Q. You review experts' reports, correct?

A. Yes.

Q. Do you regularly review litigation reports from experts in a case?

A. No.

Q. And it's true that you've never evaluated whether [236] deficiencies exist in the medical and mental health care delivery systems in California as well, right?

A. You have to rephrase what you're asking there.

Q. Sure. You have never evaluated what, if any, deficiencies exist in the medical and mental health care systems in California prisons—

A. No, I have not personally gone to the prisons and done that. I've only reviewed the reports we talked about.

Q. And in the last two years you've visited one prison, correct?

A. That's correct.

Q. Which prisons was that?

A. That was Old Folsom.

Q. When was that?

A. A little over a year ago.

Q. During your testimony, your direct testimony with Mr. Specter, you mentioned the problems that could possibly exist at reception centers; do you remember that testimony?

A. Yes.

Q. And you discuss the fact that if reception centers are overcrowded, that screenings might be missed, correct?

A. Yes.

Q. Are you aware of any inmate in a California prison who suffered an adverse medical or mental health consequence as a result of a missed screening?

[237] A. No.

Q. When you were deposed by me in this case, you could not remember why you had toured Folsom prison, but it was not in connection with evaluating the status of the delivery of medical or mental health care, correct?

A. I did not tour that prison to review the mental health or medical care. That's correct. It was done, I believe, more for the expert panel looking at programs and stuff.

Q. As a high ranking prison administrator, you do not support the use of anecdotal evidence to evaluate a prison or prison system, do you?

A. I certainly do not support anecdotal evidence, no.

Q. You agree that a single event at an institution does not necessarily apply across the entire system, correct?

A. I would agree if it's only a single event, that that should not apply across the system.

Q. And you testified, I believe, that you served on the expert panel, right?

A. Yes.

Q. Okay. And that expert panel looked at the effects of overcrowding on programming, not medical and mental health care, correct?

A. Yes.

Q. You use the term "operable"—

A. Excuse me.

* * *

[240] California's prison system, have you?

A. No. As I testified in a deposition, in order to do that, I would have to go out and visit every facility. Certainly something I'm capable of doing, but I would probably have to retire from my current job to have the time to do that.

Q. Right. So you have no idea what California's operable capacity is?

A. I have no idea what the operable capacity is, but as I said in the deposition, I did review the independent review panel's report of 2004 where a group of experienced wardens said that about 145 percent would be the maximum that the system should go for. And having met many of the staff out here I would think that a group of experienced wardens in California would have a pretty good handle on what the system could handle.

I also saw that the strike team had recommended a capacity of 130 percent. So that would lead me to conclude, if I went out and went through all of the facilities, I would come out somewhere in that 130 to 145 percent of capacity as an operable capacity for the system.

Q. But you have no idea unless you actually did it yourself?

A. That's correct, unless I did it myself.

Judge Karlton: Well, he said you have no idea.

The Witness: That's true. I'm sorry, Your Honor. I do have some idea based on what my comments that I just made to you.

[241] By Mr. Mello

Q. You believe that constitutionally adequate medical and mental health care can be provided in overcrowded conditions, correct?

A. I believe that it can be provided up to certain limitations of overcrowding, yes.

Q. And you believe that increased numbers of qualified and competent nurses, physician's assistants, doctors, psychologists, psychiatrists would improve the quality of medical and mental health care in California's prisons, correct?

A. It may. It depends whether you have all of the other infrastructure to support the staff.

Q. And that infrastructure would include correctional officers?

A. Well, the infrastructure would include correctional officers, but it would also include space to do exams, places where there's privacy so it can be done privately, you know, places that are, you know, sanitary and clean. And also the ability to provide the proper level of care once you determine what that is.

And, again, that requires a space. That requires someplace to put people. And at least from what I've seen in the reports, that seems to be a huge problem out here.

And then also, as I've mentioned, you can't be having all these lockdowns all the time, because then that is going to interfere with the ability to provide the care as well, and that [242] gets back to the safety of the system.

Q. And I believe—

Judge Henderson: Excuse me, Mr. Mello. I find the question a bit vague. Increased medical, nursing, doctors, increased from what? From when the suit was filed? From where we are right now? What do we increase all of that from to make it better?

By Mr. Mello

Q. Secretary Beard, do you have any understanding of the increased number of correctional officers since the appointment of a receiver in Plata in October 2005 through the end of August 2008; do you know what that number is?

A. I don't know what the increase is, but I know that they do have more corrections officers today, and so that is one problem area that should be of somewhat less concern.

Q. Okay. If the number increased by 2,200, do you believe that would help improve access to medical and mental health care?

A. Well, as you said, I haven't gone out and personally looked at it, so I wouldn't want to make that kind of—I wouldn't want to answer that question.

Q. Understood.

So you couldn't, based upon your experience and the reports you've reviewed, evaluate whether care would improve if the number of correctional officers increased by 2,200 correctional officers since October of 2005, correct?

[243] A. As I said, that was only one of the things I read about in the reports.

Judge Karlton: Dr. Beard, whatever the level of improvement, from your own experience, providing greater numbers of correctional officers, particularly if you have been short them, has got to have some improvement. The question is whether it makes any long term difference, which is a different question Mr. Mello is asking you about. But even one more is some incremental benefit, would you not agree?

The Witness: I would agree with that, Your Honor.

By Mr. Mello

Q. And you would agree that the hiring of 1,400 physicians and nurses since July of 2007 would have some incremental value to the delivery of medical and mental health care, correct?

A. Yes.

Q. And you testified that you believe Pennsylvania is currently providing constitutionally adequate medical and mental health care to its inmate patients, correct?

A. Yes.

Q. Do you know the average age of the offenders in Pennsylvania's Department of Corrections is 37?

A. Yes.

Q. Mr. Specter asked you about it. It sounds to me like maybe since your deposition, you reviewed the department of justice report?

* * *

[249] report?

A. Yes.

Q. You also reviewed the Deukmejian report, the Little Hoover Commission Report, the governor's emergency proclamation?

A. I did.

Q. You were part of the expert panel in 2006?

A. I was.

Q. And who created the expert panel?

A. California Department of Corrections, as far as I understand.

Q. As I understand it, you worked closely with a lot of members of that current—or not the current one, but the California Department of Corrections staff at that time, correct?

A. I did.

Q. Do you stay in communication now with the California Department of Corrections staff?

A. I've talked to the current secretary.

Q. From your experience in working with the individuals here in California that are responsible for the management of our prisons and the delivery of the healthcare in the prisons, I think you told us in your testimony earlier that good people want to move ahead trying to fix the problems; is that correct?

A. That's correct. That's my assessment of the people that I talked to, yes.

Q. They study the problem. They're doing what they can to fix [250] the problem. And you've actually seen over the—at least the last 18 months to two years steady improvements in the system, correct?

A. From reading the reports, there does seem to be some improvements over the last months, yes.

Q. In Pennsylvania the Department of Corrections is responsible not only for the conditions in the 27 prisons, but also for the county jail system, correct?

A. No, that's not correct. We—if you would like me to explain? Under the law there's a thing called Title 37, and there is—we go in and inspect those prisons, but we are not responsible for the operation of the—I mean, the county jails. We inspect them, but we're not responsible for their operation.

Q. But the Department of Corrections is responsible to ensure that the jails meet minimum standards, correct?

A. We do do reports to see that they meet certain standards, yes.

Q. And you found that in maintaining or in evaluating the conditions of the jails, that some do a very good job and some do a very poor job, correct?

A. That's correct.

Q. Of the institutions or the jails that you found did a poor job, you said that—or do you recall saying that the poor job or the bad conditions usually stem from things such as [251] overcrowding, lack of maintenance, understaffing, things of that sort, lack of resources?

A. I'm not sure what document you are talking about there, but from my review of the various reports that are done by my staff, overcrowding is a significant issue in some of the county jails that create the problem. Infrastructure problems, sanitation problems, those things are problems that I do see in the reports that I get from the county jails in Pennsylvania that are not doing what they should be doing.

Q. And it is generally from a lack of resources, correct?

A. Generally, it is a lack of resources, yes.

Q. And, generally, it's not for want of the people in the positions to want to do a good job and provide—

A. I would say in most cases that's correct. Every once in a while you run into somebody that really doesn't know what they're doing or isn't doing the proper thing, but, generally, yes, I think generally people want to do the right thing, and if they had the resources, they would.

Q. Generally speaking, that's what you've seen here in California—

A. From the people that I've talked to, yes.

Q. And the leadership, correct?

A. Yes.

Q. Now, the Pennsylvania correctional system had an overhaul that was instigated in part from riots that took place and from [252] a lawsuit that was filed, Austin Versus Department of Corrections?

A. Yes, I mentioned that earlier.

Q. And that led to a lot of reform measures being passed, correct?

A. Certainly did.

Q. And that lawsuit dealt with overcrowding and the lack of the provision of adequate medical and mental healthcare in the Pennsylvania prisons, correct?

A. What was the first part of your thing?

Q. That lawsuit dealt with the lack—

A. It dealt with not having enough resources. I would have to go back and read exactly what the lawsuit said. That's a long time ago. So, you know, if you are reading something from that document—from that lawsuit, I would assume that's accurate, because we were overcrowded at the time, and, you know, we weren't providing the care that we should have been providing.

Q. Medical and mental health care?

A. Yes.

Q. And that case was ultimately settled?

A. Yes.

Q. And in the settlement, the terms of the settlement to resolve the issues of the lack of adequate mental and medical care in Pennsylvania, you addressed—or the settlement addressed approximately five different areas, which I think you [253] alluded to earlier from the minimum number of medical and mental health, including dentists, to policies and procedures, sufficient equipment at facilities, quality assurance programs and monitoring, correct?

A. You are reading from that report. I haven't read that Austin suit for 20-some years. I will just have to say if that's—if you are reading from the report, then maybe that's accurate. I can't say that's accurate without seeing it.

Q. If the settlement covered particular—specific five areas that required improvements in the provision of medical and mental healthcare—

A. It provided for various improvements in mental health and medical care. How many exactly it was and what all those things were, I can't—I can't directly recollect without reviewing the document.

Q. In any event, it led to Pennsylvania, in your opinion, achieving constitutional healthcare and mental health care—

A. It had never been proven that we were unconstitutional at the time, but it certainly improved both the medical and mental healthcare in Pennsylvania.

Q. That was all done without a prisoner release order, correct?

A. Pardon?

Q. All done without a prisoner release order?

A. That was done without a prisoner release order, that's correct.

[254] Q. Mr. Mello touched on the death rates in Pennsylvania. Judge Karlton: sir, can I interrupt for just a moment. That's not an unimportant point.

You indicated that—I think you indicated—if I am misstating, feel free to say I got that wrong—that at least part of the problem that Pennsylvania faced when the suit was filed was overcrowding; is that right?

The Witness: That's correct.

Judge Karlton: But you achieved somehow or other a satisfactory mental and medical health without a prisoner release order. Did you do anything about reducing the prison population without a prisoner release order?

The Witness: No. No. We didn't reduce the prison population at that time. In addition to some of the changes that we made in the mental health and medical care, we also went on an aggressive construction program and added a lot of cells to the system.

And we weren't really in—as I recollect, in the position where we didn't have space to do things. It was more that we didn't have enough staff to do things, that the staffing ratios were not seemed to be appropriate. And so the—whatever changes we had to make, equipment, personnel, and stuff, we were able to make it within our existing system to meet the needs of the settlement.

Judge Karlton: Assuming that California's prison [255] system is not in that desirable of shape, do you believe that—do you believe that a constitutionally sufficient medical and mental health system can be achieved through additional building, understanding that would take time? But setting aside the time question, would you agree that that could occur?

The Witness: Theoretically, yes, sir. Yes, Your Honor.

Judge Karlton: But you don't believe it practically? Theoretically, yes; practically, no. Why?

The Witness: Well, I don't believe it practically because of the time that it takes and the costs that it takes, the huge costs that it takes to do things like this. And at least from my experience, states just haven't been willing to move ahead with that kind of thing and to do that. So and construction, if you start building today, at least in my state, I probably can't get a prison in three years. It's probably going to be closer to four years to get a prison up and running. And then if you need a whole bunch of prisons—you know, for instance, one of the problems or concerns I have about AB 900 is the in-fill backs, because all you're doing is building another place for these people to be. It's still an overcrowded prison.

So, you know, you'd have to go out and build a whole bunch of prisons to really do this, and that's going to take you years, because you are going to be three or four before you get the first prisons, and you can't build, like, you know, 30 [256] prisons all at once. So you'd be, like, seven, eight years out, nine years out before you get to the place where you have the proper thing.

That's why I think the construction, in my mind, while certainly it should be a part of any plan and should be part of a plan, if you try to rely on that alone, you are probably never going to get there, because they haven't been able to get there over the last 20 years.

Judge Karlton: Sorry to have interrupted, counsel. Mr. Mitchell: thank you.

By Mr. Mitchell

Q. regarding the death rates that you and Mr. Mello spoke about, would you agree that the majority of deaths result from conditions present at the time of incarceration in a prison system?

A. Would I agree that the majority of deaths result from the conditions in the prison system?

Q. No. Conditions that are present in the individual inmate at the time of incarceration.

A. Where are we talking about?

Q. They come into the prison with their diseases.

A. Well, many inmates do come in—inmates are not as a rule a healthy part of our population. They have bad lifestyles. They get involved in a lot of things they shouldn't get involved in, which does drive some of the healthcare issues and problems that

* * *

[259] Mr. Mitchell: Thank you, Dr. Beard.

Judge Henderson: Counsel, redirect?

Redirect Examination by Mr. Specter

By Mr. Specter

Q. Mr. Mitchell asked you questions about the—about whether the staff in California want to do the right thing and provide the care and custody that their prisoners are constitutionally entitled to in prisons; do you recall that discussion?

A. Yes.

Q. Do you believe under the current overcrowded conditions they can do the right thing?

A. No.

Mr. Specter: No further questions.

Judge Henderson: Okay. That looks like—

Judge Karlton: Let's excuse the witness first.

Judge Henderson: That's what I was going to say. It looks like we're finished with the testimony. Thank you very much for appearing, Mr. Beard. We will now take a 15-minute recess.

(Recess taken.)

Judge Henderson: Okay. You may call your next witness when you are ready, counsel.

Mr. Specter: Thank you, Your Honor. Plaintiffs call Joseph Lehman.

Judge Henderson: Step forward and be sworn in, sir.

[260] Joseph D. Lehman,

Having been called as a witness by the plaintiffs was first duly sworn and examined as follows:

The Witness: I do.

The Clerk: Spell and state your full name for the Record.

The Witness: Joseph D. Lehman, L-E-H-M-A-N.

Direct Examination by Mr. Specter

By Mr. Specter

Q. Good morning, Mr. Lehman.

A. Good morning.

Q. Mr. Lehman, what's your current occupation?

A. I am the administrator of a parish, a church, in Lakewood, Washington.

Q. Are you in any sort of training program?

A. Yes, I am, in the Deacon Formation Training program, which is an ordained minister's program.

Q. Before that, you worked in corrections, did you not?

A. Yes, I did.

Q. And for how many years?

A. Approximately 35 years.

Q. And during that time, were you in charge of any states' prisons systems?

A. Yes, I was.

Q. Which ones?

[261] A. Pennsylvania, and Maine, and then the state of Washington.

Q. And which state did you spend the majority of your time in corrections?

A. In the state of Washington.

Q. How many years did you work there?

A. About 29 years.

Q. And could you briefly describe what positions you held, just briefly, please?

A. I worked in all parts of the corrections department, including the community side, the prison side, work release, and in management of the system.

Q. And during your time in Washington, were you responsible for the operation and/or management of any of the prisons?

A. Yes, I was.

Q. How so?

A. I was, in fact, what we refer to as a Command Manager of a complex of three prisons in Monroe, Washington, and subsequently I was the Director of Division of Prisons.

Q. And could you describe the chronology of—first, you were in Washington, then what state did you go to in what capacity?

A. Of course, first I was in Washington until about 1990. I went to Pennsylvania to head up the Pennsylvania Department of Corrections. Subsequently, to the state of Maine to head up their department. And, ultimately, back to Washington to head up the Department of Corrections in Washington State.

[262] Q. I see. When you became the Secretary of Corrections in Pennsylvania, did you reorganize that department in any way that affects the delivery of healthcare?

A. Yes, I did. When I came into the Department of Corrections, there was not a centralized authority. There was not a centralized authority in relation to healthcare, so I created a Director of Healthcare Services.

Q. And did you do something similar in Washington state?

A. Yes, I did. The same set of circumstances. Healthcare existed within the prison system, but there was no coordination of that healthcare, no means of ensuring continuity, so I created a director of healthcare services in the state of Washington.

Q. Could you maybe—I'm having trouble hearing you, and it's not you; it's the acoustics in the room. So maybe you could just stay away from the mic just a little bit.

When you created those divisions, did you still maintain any responsibility for healthcare?

A. I was certainly responsible for the promulgation of the policies and procedures, ultimately for the policies and procedures of the healthcare program, as well as for the oversight of the director of healthcare services.

Ms. Johnson: Your Honors, excuse me. I couldn't understand any of that answer.

Judge Karlton: I don't know what we can do. You

* * *

[267] The Witness: I do not know, Your Honor.

By Mr. Specter

Q. In your opinion, could you have provided—well, you eventually resolved the lawsuit and were able to provide what you believe to be constitutionally adequate healthcare; is that right?

A. That's correct.

Q. And could you have provided that adequate care without reducing the prison population?

A. Did I provide the care without—

Q. Could you have done that without—

A. No.

Q. Okay. Now, you're familiar with the term "hot bunking"?

A. Yes, I am.

Q. It's been described before by Mr.—Dr. Beard, so I won't bother asking you what it means again. But have you ever heard of it being done in prisons?

A. No, I have not.

Q. And it was never done in any of the systems, including Pennsylvania?

A. It has never been done in any system that I ran or am familiar with.

Q. Okay. The state of California, did they ask you to participate in what is commonly referred to as the expert panel?

A. Yes, I was asked to participate in that endeavor.

[268] Q. And you were asked by the State of California, correct?

A. That's correct.

Q. And that panel was designed to provide recommendations to the state for improving programming within the Department of Corrections and Rehabilitation; is that correct?

A. That's specifically rehabilitative programming.

Q. Right. When was that?

A. It was—the panel was pulled together in December of 2006. It really actually operated in 2007.

Q. Okay. After that panel completed its work, did the state ask you again to perform any other service?

A. I was asked to participate along with a couple other individuals, on what they referred to as a strike team, governor's strike team, to assist in the implementation of the recommendations.

Q. During—what was the first recommendation of the expert panel?

A. Reduce overcrowding.

Q. Okay. And was that because the panel believed that without a reduction in overcrowding, it would be difficult, if not impossible, to provide the programming the panel also recommended?

A. That was quite evident. It was a prerequisite to doing anything else.

Q. And the same logic applies to providing many healthcare [269] services, does it not?

A. That is correct.

Q. And in the course of this work on rehabilitative programming, you became aware of the overcrowding in California's prisons; is that right?

A. Yes, I did.

Q. Okay. And you toured some of the prisons in connection with that work?

A. In connection with the expert panel and the strike team, yes.

Q. Okay. What was your impression from the tours as it relates to overcrowding?

A. It was immediately evident, given not only the testimony of the staff that were present, but the fact that we were observing otherwise program space, such as education space, filled with inmates in terms of dormitories, as well as recreations, gyms filled with beds and bunk beds.

Q. And did you talk to any staff during your tours?

A. Yes, we had conversations with the staff, external custody staff, within the cell blocks.

Q. And did they tell you anything that relates to overcrowding?

A. They indicated that it was a very difficult situation to be in. They certainly recognized, as we did, the overcrowding and triple bunking and indicated it was a difficult—it was difficult to operate in those circumstances.

[270] Q. Okay. And in your experience—you know that California's about 195, 196 percent of design capacity, correct?

A. Yes, I do.

Q. In your experience, have you ever known of a correctional system that was this high?

A. Never.

Q. Okay. In your experience, how does overcrowding affect the delivery of healthcare?

A. Well, initially, overcrowding in and of itself contributes to the difficulties of healthcare delivery by virtue of the fact that it increases the incidence of illnesses, infectious disease. It increases the amount of tension, the level of violence, certainly requiring responses, both in terms of custodial and medical.

It is a situation where the demand significantly outstretches the ability to respond to the healthcare needs, both in terms of timing and actual service.

Q. And you're aware that the courts in the two cases that we're present—of this present proceeding have either declared or there's been a stipulation to the fact that they're unconstitutional; is that correct?

A. Yes, I am.

Q. The delivery of care is not adequate, correct?

A. Yes.

Q. Based on the information you received about California's [271] Prison system, what's your opinion about whether overcrowding is the primary cause of the unconstitutional healthcare?

A. I think that is the primary cause of the inability to provide the services. It's overwhelming the system both in terms of sheer numbers, in terms of the space available, in terms of providing healthcare.

My understanding, for example, is you could have an institution at 200 percent capacity, but the healthcare—the physical space provided is based on the hundred percent population as opposed to 200 percent. So it's simply not able to provide the services that is required.

Q. Okay. You are aware that the receiver—judge Henderson appointed a receiver to improve the medical care system and then actually to run the medical care system in California?

A. Yes, I am.

Q. What do you say to the argument that the court should not reduce the population because there's this receiver who's got authority to make improvements?

A. I think you have to address the overcrowding. It is so overwhelming, it's overwhelming in the sense of not—of not being able to meet the immediate demands, but it's overwhelming, exasperating the problem in the first place. You cannot Provide—in my opinion, you cannot provide adequate healthcare and mental healthcare under the current situation of crowding within the state of California.

[272] Q Is that true even though the receiver has been able to hire additional both custodial and clinical staff?

A. I understand that, but the problem still exists because where's this space that you are going to provide those services in? I mean, where are the providers going to work and how—and, by the way, the actual reports indicate they are not able to provide the services.

Q. so would that—would it be fair to say that unless you have what we've referred to as the infrastructure to allow the care to be provided, just hiring staff itself isn't going to work?

A. It's not going to—it's not going to, given the overcrowding.

Q. Now, when you were the secretary of the Department of Corrections in Pennsylvania, the population in the prisons was—it was overcrowded, right?

A. Absolutely.

Q. Did you inform the governor of your state, of that state, of that problem?

A. Yes, I did.

Q. And what was his response?

A. His response was, well, we have to, in fact, engage in activities to, in fact, reduce that population.

Q. Now, if you were the secretary of corrections for the department of California, what would be the first thing you'd [273] say to the governor?

A. I'd say to the governor, you are not going to provide adequate services to this population without reducing the population.

Q. Okay. Now, two last questions for you.

In your—is it 35 years of experience?

A. Yes.

Q. —thirty-five years of experience, how many times have you testified on behalf of prisoners?

A. This is the first.

Q. And why are you doing this today?

A. I think the situation in California is so egregious—I mean, I've worked in systems where there was overcrowding, a level of overcrowding. Washington state system was 150 percent when I took over as secretary. It was 107 when I left. The Pennsylvania system was, in fact, over 150 percent overcrowded. It was down to operating capacity when I left. You have to deal with the overcrowding.

Q. It's as simple as that?

A. Yes.

Mr. Specter: Thank you. No further questions.

Judge Henderson: thank you, counsel.

Does CCPOA counsel have any questions of this Witness?

Ms. Leonard: No further questions, Your Honor.

* * *

[277] Q. Okay. Well, if I could refresh your recollection, when I asked you the same question at your deposition you said you didn't recall having read those types of articles.

A. Well, the articles I did. I'm sorry.

Q. So you served on the California Department of Corrections and Rehabilitation expert panel on adult offender and recidivism reduction program, correct?

A. Yes, I did.

Q. And that title kind of speaks for itself, doesn't it?

A. I think so.

Q. So that expert panel did not address healthcare issues in California's prisons, did it?

A No, it did not.

Q In your report—

Judge Karlton: Dr.—I'm sorry. Mr. Lehman, do you have to be a doctor to figure out that you got to have the space to treat people in order to treat them effectively?

The witness: no, you do not. In fact, it would be the secretary's responsibility to assure there were sufficient space and access to those services.

By Ms. Johnson

Q. In your report that you prepared for this case in August of 2008, you did not review--in preparing that report, you did not review any of the Plata receiver's reports, correct?

A. No, I did not, at that time.

[278] Q. In preparing your report, you did not review any of the Coleman special master's reports, correct?

A. No, I did not.

Q. In preparing your report, you did not know what the space needs were for medical or mental healthcare in California's prisons, did you?

A. Specifically, no.

Q. You did not tour a single one of California's 33 prisons for the purposes of preparing your opinion regarding the impact of overcrowding on medical or mental healthcare, did you?

A. Not for those purposes, no.

Q. When you prepared your report, you did not have knowledge of the status of medical care delivery in California's prisons as of August 2008, did you?

A. I'm sorry. Repeat the question.

Q. When you prepared your report, you did not have knowledge of the status of medical care delivery in California's prisons as of August 2008, did you?

Mr. Specter: object as vague.

Judge Henderson: vague? Vagueness?

Mr. Specter: vague.

Judge Henderson: let me ask the witness. Do you understand the question?

The Witness: Repeat the question.

[279] By Ms. Johnson

Q. When you prepared your report—

A. Yes.

Q. —you did not have knowledge of the status of medical care delivery in California's prisons as of August 2008, did you?

A. No, I didn't. Only about the overcrowding itself.

Q. When you prepared your report, you did not have knowledge of the status of mental health delivery in California's prisons as of August 2008, did you?

A. No.

Q. You did not prepare the first draft of your report in this case, did you?

A. I had conversations with Mr. Specter. We did talk about the overcrowding. We talked about the impact of the overcrowding in the system, particularly in terms of its classification, the appropriate housing of inmates. On that basis the report was drafted.

Q. Did you write the first draft of your report, Mr. Lehman?

A. No. I asked Mr. Specter to do that based on our conversations.

Q. So it's your testimony that plaintiff counsel, Mr. Specter, wrote the first draft of your report?

A. Based—once again, based on our conversation.

Q. On page 3 of your report—if we could have that up?

(Document displayed.)

* * *

[285] [Judge Karlton: I keep forgetting those guys are there.

By Ms. Johnson

Q. "Severe overcrowding like that Affecting California prisons results in a lack of treatment and office space and decreased Access to healthcare services."

When you prepared your report in this case, you did not know of even one specific instance in the preceding year where a prisoner was denied access to healthcare services due to severe overcrowding, did you?

A. I did not know of a specific case.

Q. On page 4 of your report, again at paragraph 10, you wrote: "overcrowding reduces the opportunity for prisoners to program which causes obvious Idleness."

You are not aware of any instances where prisoner idleness resulted in the denial of needed mental healthcare or medical healthcare, are you?

A. Specific cases again, no.

Q. At times when you were secretary of the Washington State Department of Corrections, the prison population exceeded the system's design capacity, correct?

A. That's correct.

Q. At times when you were secretary of the Washington State [286] Department of Corrections, the prison population exceeded the prison system's operational capacity, correct?

A. That's correct.

Q. It is your opinion that the Washington State Department of Corrections was still providing adequate medical and mental healthcare at the times the prisons were above even operational capacity when you were secretary, correct?

A. That's correct.

Q. So, in your experience, it is possible for a prison system that is above operational capacity to provide adequate medical and mental healthcare, correct?

A. Depending on the level of crowding, there is a significant difference of the level of crowding in the state of California and any other jurisdiction that I have been involved in.

Judge Karlton: but the question is—let's start from the beginning. It is possible at some level of overcrowding to nonetheless provide adequate care?

The Witness: At some level, yes.

Judge Karlton: But your opinion is that California's overcrowding, I take it that—feel free to tell me I got it wrong. I take it that your opinion is that California's system is so overcrowded that that is not possible?

The witness: That is my opinion. It is—I don't know of another state, Your Honor, that has experienced anything close to this level of overcrowding. It is just—it just [287] doesn't exist.

By Ms. Johnson

Q. When you were in Pennsylvania and you had that lawsuit that was brought after the riots—you and Mr. Specter spoke about on direct, you recall that?

A. Yes, I do.

Q. One of the solutions was shipping 800 of the prisoners to federal bureau of prisons?

A. That's correct.

Q. And another solution was building five more prisons in three years?

A. There were five prisons built in five years, but there was additional other things. We went to the legislature. We created new sentencing laws. It was a state similar to California. The sentencing grid in Pennsylvania at the time, Your Honor, initially was —only allowed for sentence of total confinement. We modified the grid and allowed more intermediate sanctions and non-total confinement centers.

Q. One of the solutions was to build more prisons, correct?

A. That's right.

Q. Mr. Lehman, just to clarify, you were paid by plaintiffs to testify in this case, were you not?

A. Yes.

Judge Henderson: Counsel?

[288] Cross-examination by Mr. Kaufhold

Mr. Kaufhold: Steve Kaufhold for the Legislative Intervenors.

By Mr. Kaufhold

Q. Mr. Lehman, I want to ask just real quickly about the resolution of the Austin case that you testified about earlier. Were you still the secretary when that case was resolved?

A. Yes, I was.

Q. And as part of the resolution of that case, or at the time of the resolution, did you believe that the Pennsylvania system was overcrowded?

A. Yes, I did.

Q. And when you—

A. At the time of the resolution or the time of the—in either case, yes.

Q. And when the case was resolved, the resolution did not involve a prisoner release order; is that correct?

A. That's correct.

Mr. Kaufhold: No further questions.

Judge Henderson: Redirect?

Mr. Specter: I couldn't hear his last answer. Could you read that to me, please?

Judge Karlton: The last answers was "yes."

Mr. Specter: I'm sorry.

Judge Karlton: "When the case was resolved, the [289] resolution did not involve a prisoner release order; is that correct?

"Answer yes."

Mr. Specter: Thank you.

Redirect Examination by Mr. Specter

By Mr. Specter

Q. Was the prison population—was the crowding lower than it was when the case was filed?

A. I'm sorry, counsel?

Q. I'll start—I'll back up a little bit.

Speaking of the Austin case?

A. Okay.

Q When it was filed, you were at about 150 percent of overcrowding, right?

A. That's correct.

Q. What was the percent of overcrowding when it was resolved? Was it lower or higher or what?

A. Actually, it was resolved within several months, and it was resolved on specific commitments we made in terms of building and reducing the crowding.

Q. Okay. And when the level of medical care met the requirements of the settlement—first, you had a settlement which required you to improve the medical care system; is that right?

A. That's correct.

* * *

[293] Judge Karlton: It's all in evidence, and she's just repeating it. And it's her time, if she thinks that is a useful thing to do, to spend it on.

Ms. Kahn: Shortening the time, Your Honors.

He's been qualified as an expert in numerous federal cases on prison conditions, including in the Coleman trial.

We now offer Dr. Haney as an expert on the psychology of imprisonment and impact of prison conditions, including overcrowding of prisoners in the prison systems.

Judge Henderson: court will find he is so qualified. Thereupon—

Dr. Craig William Haney

Was called as a witness on behalf of the plaintiffs, and after having been first duly sworn, was examined and testified as follows:

Direct examination

By Ms. Kahn:

Q. Dr. Haney, I would like you to briefly explain what is overcrowding in prisons and in what ways does overcrowding in prisons effect the functioning of a prison system?

A. Overcrowding in a prison system can be defined as a prison or prison system holding more people than it has the resources to humanly and safely accommodate.

So it means what it means in most other contexts: having too many people in a particular environment. But in a

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[296] system at the time the prisoners are there. And then, there's this other dimension that I alluded to a moment ago, which is when prisoners are released from prison, if they are released with unmet needs or problems that have not been resolved or issues that have not been addressed while they are incarcerated, they are at risk of coming back into the system oftentimes with those problems the same or having exacerbated after they are released.

So, again, the period of time that the system is overcrowded matters, because the longer the overcrowding occurs, the longer the system operates, and the greater the number of unmet needs that aggregate over time, the worse the situation gets.

And as I said, as a result overcrowded, particularly severely overcrowded systems, tend to begat even more overcrowding, because they are not solving problems that over time either have to be solved or result in people coming back into the prison system at higher rates.

Q. In what ways is California's prison system overcrowded? A. It's overcrowded in virtually every conceivable way one would measure overcrowding. It's overcrowded in the sense of having far too few spaces for people to be housed. And in a

Certain sense, that's the most basic and focused definition of overcrowding. So as I'm sure the court knows, this system has been operating at roughly 190 percent of capacity.

[297] 190 percent of capacity comparatively speaking is almost an unheard of number, an unheard of amount of overcrowding operating at a level beyond physical or design capacity of the system.

The physical or design capacity takes into account not only the number of spaces that are available for people to live in, but design capacity also is calculated on the basis of programming in other necessary space within the system.

So a system that is operating at 190 percent of capacity has not only approximately half the spaces available for people to be housed in, but it also has approximately half of the spaces that are available to provide programming and other kinds of support within the system.

California is—so the depth of the problem or the magnitude of the overcrowding is almost unheard of. And I say that, when I say "almost unheard of," I mean even historically almost unheard of.

In a period of time in the last 30 years when lots of prison systems have been very overcrowded, a level of overcrowding of 190 percent is remarkable. It's not unprecedented, but it's remarkable.

California's overcrowded in another sense. And that is in the sense that the overcrowding is widespread. It is not restricted to just a few institutions. It's occurred throughout the system.

[298] So you're looking at individual prisons that are operating at 180, 190 or even over 200 percent of capacity. And that's essentially across the board in the system. It's overcrowded in a comparative sense.

I know of no other large prison system in the United States that is as remotely overcrowded as California is.

As best I've been able to determine, the only state that is as—that is even close to California in terms of extent of overcrowding is the state of Alabama, a very, very small system compared to California's.

And it's overcrowded in the final sense in that it is —it has been overcrowded for a long period of time. It began to be overcrowded 10 or so years ago. It has continued to operate. It began to be overcrowded even longer than that ago, but it began to be severely overcrowded 10 or so years ago and has continued to operate for the last five or six years at a level of overcrowding that, as I said, is roughly 190 percent of capacity.

And on all of those measures that is an extraordinary level of overcrowding.

Q. Dr. Haney, What is your opinion of whether overcrowding in the California prisons is the primary cause of the Constitutional violations in medical and mental healthcare?

A. Well, my opinion is for all of the reasons that I just stated that the level of overcrowding is unprecedented in that [299] There is no question that it is the primary cause of the unconstitutional provision of mental healthcare in the system.

Q. In forming your opinion, is it correct that you relied on key documents in the case produced by the defendants and special master and receiver, and you toured eight California prisons?

A. Yes, that's correct.

Q. During your tours did you speak with prison staff and interview prisoners during the eight prison site inspections?

A. Yes. Every one of the inspections there was a briefing, and then there were officials from the prison who accompanied us throughout the tour.

Q. Do you rely on these type of interviews with prison staff and prisoners in the course of your work as an expert?

A. I do all the time.

Q. Do others in your field rely on these type of interviews with staff and prisoners?

A. Yes, of course.

Q. Okay. Did you also on your tours of CDCR staff persons on the last four prison site inspections take photos that you directed to have taken?

A. Yes, we didn't have a camera in the first four, but we did on the second four. And we had photographs that were taken.

Q. Okay. I'd like to turn to the prison site inspections that you undertook in the case which formed the basis of your opinion, and ask you what you saw during the site inspections [300] that led you to include that overcrowding was the primary cause?

A. I saw a system as reflected in each one of these inspections that was overwhelmed with the sheer number of people who were confined there. These were systems that were choked with too many prisoners, not enough space, insufficient amount of staff.

In almost every direction that I turned I saw evidence and examples of this, of a system operating at roughly 200 percent of its capacity and straining under the weight of that capacity.

Unable to deliver services, unable to address the needs of the people who were in the system. I saw and heard from individual prisoners and numerous staff members about all of the overcrowding-related problems that they were confronting on a daily basis, whether it ranged from the kind of housing that prisoners were forced to live in in the California system, housing in some instances unlike housing I've seen anywhere else in any other prison system. And I've been looking at prisons for a long time.

I saw—

Q. And what type of housing were you talking about?

A. I'm talking about prisoners living in converted or makeshift dormitories. Prisoners stretched out in double and triple bunks as far as the eye can see. I'm talking about a very bizarre housing unit in California institution for men in the Colusa unit where there's a dormitory has been created inside the [301] housing unit in the dayroom of the housing unit and a chain link fence has been placed around the dormitory inside that housing unit.

There were dormitories in many of the regular housing units in the prisons that had been conveyed from dayroom spaces. As you probably know, most prison housing units have areas, dayroom areas where prisoners can congregate during the day when they are not in other activities and they are not in their cells.

In virtually every prison I toured and inspected many of these dayrooms had been converted into dormitories. So there were double and triple bunks now placed 20 or so on the side of each one of the—

Q. What other areas, Dr. Haney—excuse me—did you see where overcrowding had impacted the delivery of care during your tours?

A. What other kinds of areas?

Q. Besides housing?

Ms. Tillman: if I might just ask Ms. Kahn to get a little closer to the microphone. Her voice is not carrying—judge Henderson: do that, please.

Let us know if it works.

By Ms. Kahn:

Q. Housing was the first area?

A. Housing was very much connected to programming. So it's not [302] just how people were living, what they are doing in their cells, how they are being confined in their cells and what kind of cells or dormitories they are in, but overcrowding has a direct impact on programming.

The levels of idleness in the California Department of Corrections are severe and widespread. It is the case that roughly fifty percent of the prisoners who exit the California Department of Corrections at any given time have not participated in a single program, not an educational program, not a vocational training program, and not a work program.

So they have been idle during their entire period of time in the Department of Corrections. And that was obvious in the various housing units that I've toured.

So programming is impacted.

Judge Karlton: this is not a case in which the plaintiffs have charged that by virtue of overcrowding there is a general unconstitutional condition. It specifically relates to whether overcrowding is the primary cause of the failure to deliver constitutionally-adequate mental and physical health.

I don't want to cut you off, but I do want to get to what this case is about.

Ms. Kahn: Exactly.

Judge Karlton: would you discuss that with us, sir?

The Witness: Those things are related. The environment in which people live is related to their mental [303] health. The kinds of adverse living conditions that I saw are the kinds that have been associated with adverse mental health consequences in a number of different settings.

Idleness is also something which also undermines people's mental health. So we're talking about a system which is capable of either generating or exacerbating adverse mental health conditions as a result of the general conditions of confinement. But there were many other more specific issues that I confronted and observed as I went through these institutions that speak directly to Your Honor's point.

The access to appropriate levels of care was directly impacted by the level of overcrowding. And there were examples of this in numerous different contexts.

The ability of the system to move people who were in crisis, sometimes suicidal or decompensating prisoners in the mental health crisis beds. These are crisis beds covered by title 22.

There's a certain specified kind of bed, kind of bed a person who is in need of a mental health crisis bed are to be placed in.

There are time lines for placement of people in these beds. Everywhere I went in the system I saw alternative housing or waiting areas where prisoners who were waiting to get into these mental health crisis beds were being housed. Not for hours, but days at a time.

[304] In some instances in terms of the more short-term confinement, they were being housed in cages that exist in the different parts of the prison.

Sometimes in hallways, sometimes on the dayroom floor of a particular unit, they were housed in waiting rooms. They were housed in outpatient housing unit, unlicensed facilities or clinics within the prison system itself, backed up in the system awaiting an opportunity to get into a mental health crisis bed of the sort that they needed.

Judge Karlton: Let me interrupt, again, sir. In your view, is the delay which you are describing and the kind of housing units that were being occupied by people who were backed up, if you will, contributing to the mental health problems of the population; or they were just sick beforehand, and they couldn't get treatment, or both?

The Witness: I would say both, Your Honor. I believe that these were people who were, by definition, sick, but they were getting sicker as a result of their inability to get the appropriate level of care.

In some instances there were examples of people who started out relatively well who either had no mental health background or who were at a lower level of mental healthcare need. And I interviewed and saw in their records examples of them not getting the appropriate level of care, and then working their way towards more and more extreme needs, a higher level of

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[316] 5,000 people who need the mental healthcare provided in the EOP program is a measure of index of unmet need.

And that gap, that gap which I've described as unmet need, has been increasing over time, not decreasing. And that, too, speaks to the issue of overcrowding in my opinion.

Q. And how did overcrowding impact those 4,000 that could be housed in EOP programs?

A. Well, the overcrowding has impacted those people, even the people who are fortunate enough to be in the EOP program, in a number of different ways.

I talked earlier about treatment space. Many of the EOP programs are severely compromised in terms of the amount of available treatment space that they have. So even though there are EOP programs, they don't have a sufficient amount of space in which to engage in therapeutic or treatment activities.

They are impacted by staff shortages, as well. Staff shortages that are reflected not only in the actual vacancies, but also on the basis of the special master's workload study, vacancies or staff shortages which are even greater than those reflected in the actual Department of Corrections vacancies.

They're impacted, in addition, by another overcrowding-related issue that plagues the California systems: lockdowns. Lockdowns are used in the California Department of Corrections, i believe, in large part because of the profound level of overcrowding at a level that is unheard of in [317] corrections departments across the United States with which I'm familiar.

Lockdowns mean that prisoners, including EOP prisoners, if they are in a unit that is locked down, are essentially without programs during the periods of time that the lockdown is in place.

There are housing units in the California Department of Corrections that are locked down more often than they are unlocked.

There is a notorious facility in the Salinas Valley State Prison which is locked down almost all the time. And where obviously prisoners, some of whom are on the mental health caseload, are not receiving any treatment, therapy or otherwise, in the course of the lockdown.

Q. Thank you, Dr. Haney.

So can you quickly sum up why you concluded overcrowding is the primary cause?

A. I don't believe in a system this overcrowded at this magnitude of overcrowding with overcrowding as widespread as it has been in California for as long a period that it has been that there's any other plausible or credible explanation for the failure of the system to provide constitutionally-adequate mental healthcare.

The court's been monitoring this issue for many, many years. There have been many, many court orders, and there have [318] been many activities that have been engaged in in trying to bring this system's mental healthcare delivery into constitutional compliance.

In the face of all of those efforts there has been this overwhelming overcrowding problem of such a degree, magnitude and duration that it has incapacitated the system's ability to deliver constitutionally-adequate care. And I saw numerous examples of it when I toured, and numerous examples of it reflected in the documents I reviewed.

Q. Thank you.

Judge Henderson: I have a question that goes back, Dr. Haney. In the Salinas prison which you described as being under lockdown almost all the time, are you able to determine is this because of the level of overcrowding there is more severe, or do they have a warden who holds the lockdown trigger faster, or do you know?

The Witness: As best I can tell Your Honor is that particular housing, it's a large housing unit, about a thousand prisoners. We're not talking about a small unit in this prison. It's a facility that is locked down, and it's a facility that is beset with a lot of conflicts. And overcrowded systems tend to respond to conflicts with lockdowns. And that's what has been happening in California, and that's what is happening in that particular prison.

And what it results in is a large number of [319] prisoners, many of whom have mental healthcare problems, being locked in their cells around the clock for weeks and months on end.

Judge Henderson: Thank you.

CCPOA counsel have any?

Ms. Leonard: No further questions, Your Honor. Judge Henderson: okay.

Cross-examination.

Cross-examination

By Ms. Tillman:

Q. Good afternoon. This is Lisa Tillman on behalf of the Coleman defendants.

Good afternoon, Dr. Haney.

A. Good afternoon.

Q. Dr. Haney, I understand that you've testified in various courts, including federal courts, a number of times in a number of different cases; is that correct?

A. Yes.

Q. And you've even testified as an expert at the underlying trial of the Coleman case, correct?

A. Yes, I did.

Q. You've testified on correctional issues in the Ruiz case in Texas, a class action case in Texas, correct?

A. Yes. Yes.

Q. In the gates case involving the California medical facility,

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[346] Ms. Kahn: objection.

Ms. Tillman, can you read the rest of this quote.

Ms. Tillman: this goes on for over a paragraph, Your Honors. I'm happy to allow Ms. Kahn to engage in redirect, if she needs to.

Judge Henderson: let's do it that way. That's fine. By Ms. Tillman:

Q. Isn't it correct that you've concluded that the reduction of the overall California Department of Corrections rehabilitation population is only the first step towards a constitutionally-compliant mental healthcare system?

A. Yes, it's a necessary but not sufficient condition. If that's all you did and you stopped there, then than wouldn't do it. But I don't believe you can do it without doing that, because it is the primary cause of the problems that I've been describing.

Q. And I believe at your deposition at page 118, at line eight through 20, you said it very well.

Let's see if we can get a better resolution on that. You said:

> "It's one step, yes, absolutely, an extremely important step in my opinion. I think a necessary, but not sufficient condition." You were asked:
>
> "But even after implementing that condition other [347] steps must be taken by defendants to reach constitutional compliance, right?
>
> "Answer: yes. And we've been talking about staffing. We've been talking about programming space. We've been talking about all these other things that are part of a constitutional system," Correct?

A. It's what I said in the deposition. It's what I've said here.

Ms. Tillman: Thank you. Nothing further.

Judge Henderson: okay, counsel.

Ms. Kahn: Okay.

Judge Henderson: any Intervenors wish to cross-examine this witness?

Ms. Johnson: Anne Johnson for the Plata defendants.

Similar to the motion to strike we made yesterday with respect to Dr. Stewart's testimony, the Plata defendants move to strike Dr. Haney's bare conclusions regarding medical care and the primary cause of the alleged constitutional violations in the Plata case as lacking any factual basis or explanation.

We would note that Dr. Haney is not a physician. And all of his testimony relates to the Coleman members and the mental health issues, not medical care.

The court: similar to the ruling yesterday, motion's

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[353] the plans is wide and widening.

Q. Ms. Tillman also was asking you questions about ADSEG and single celling. And I'd like you to address how overcrowding affects prisoners who are housed in ADSEG on single cell status.

A. Well, overcrowding affects them in a number of significant ways. It over—it affects them, first of all, in terms of an issue that I've been talking about repeatedly, which is access to treatment space.

Whether a prisoner is single or double-celled in the administrative segregation, their access to treatment space is severely limited by the overcrowding that plagues the system.

The treatment spaces are as I've described them. The court has seen pictures of the cages which are used. What are not depicted in those photographs are the location of those cages in some of the administrative segregation units that I toured.

Many of them out on the dayroom floor of the administrative segregation units, so that if a prisoner is engaged in allegedly therapeutic activity, that's witnessed by all the other prisoners in administrative segregation.

Group therapy sometimes takes place in a tiny area where it's almost impossible for the cages to fit in the area.

In many instances, prisoners, even single-celled administrative segregation prisoners are affected by overcrowding because of the shortage of clinical staff to [354] provide them with the treatment opportunities that they are entitled to.

They are impacted by overcrowding because of the shortage of escorts. An administrative segregation prisoner has to be escorted by a correctional officer whenever they leave the administrative segregation unit to get access to therapy or to get access to anything outside of the administrative segregation unit.

In addition, they are impacted by overcrowding because of the difficulties of the administrative segregation units in providing the constitutionally-mandated access to exercise.

Q. How is exercise provided to prisoners housed in ADSEG?

A. Well, they have to be individually escorted to the exercise area. Many of them, they typically exercise by themselves. And there are inadequate number of those exercise facilities available.

And there's sometimes called "small management yards." the court has ordered those small management yards to be constructed so that prisoners who are in administrative segregation can get this access.

It's not being provided now. And, in part, it's not being provided because there's a resource shortage, an, I believe, overcrowding-related resource shortage.

In some instances administrative segregation units [355] themselves, even though they are already locked down units are locked down even further.

I toured an administrative segregation unit in the California correctional institution in TEHACHAPI where there had been a violent incident that had occurred in the beginning of April of this past year.

I toured that unit at the end of July. The prisoners in that unit had been locked down and had not gotten outdoor exercise because that unit had been locked down. That administrative segregation unit had been locked down from the beginning of April until the end of July. So not only were they not getting 10 hours a week of outdoor exercise, they were getting no hours a week of outside exercise.

Lockdown is a direct result of a system being overcrowded and overwhelmed and having too many people and not having a way to manage conflicts in any other way. And it can impact even administrative segregation units.

Q. Thank you.

No more questions.

Judge Henderson: Okay. Thank you, counsel. Okay. We're going to take a 15-minute recess.

Ms. Tillman: Your Honor, can I just ask one or two More questions?

The Court: Certainly. Sorry, Ms. Tillman.

Ms. Tillman: I'll try to keep it short.

[356] Judge Henderson: it's your cross-examination.

Recross-examination

By Ms. Tillman:

Q. Dr. Haney, you've mentioned concern about the use of therapeutic modules for providing group therapy for the most violent of the patients on the mental health caseload, haven't you?

A. Patients who are in administrative segregation typically receive therapeutic programming in the cages that we've been talking about.

Q. Have you ever had a conversation with court-appointed expert Dr. Metzner about those therapeutic modules and their design?

A. I know Dr. Metzner. I don't know that we've ever talked about the particular therapeutic modules that I've described in the report and that the court has pictures of.

Q. Were you aware that Dr. Metzner provided the specifications for design of those therapeutic modules?

A. Ms. Tillman, I'm fairly certain Dr. Metzner did not provide the specifications for the therapeutic modules that I saw in the administrative segregation units that I toured, some of which the court does have photographs of.

We're talking about old cages that have not been recently created that Dr. Metzner cannot possibly have had any input into because they have been around in this system for a long time.

[357] Q. So you would approve, then, the use of therapeutic modules that have been built recently, say in the past year, pursuant to the specifications provided by Dr. Metzner then, wouldn't you? A. No, I didn't say that. And let me try to address this. I think I understand the context of this, and if I don't I hope you'll correct me.

Q. I think you've answered the question, actually.

Ms. Kahn: Objection? Can the witness answer the Question?

The Witness: I know that Dr. Metzner has had some input sometime ago in the creation of therapeutic modules or cages that were originally intended for use in a therapeutic environment, psychiatric services as a matter of fact.

When the issue was how to provide care in a therapeutic context like a PSU for prisoners who also had serious or significant security concerns or issues. It's a hard problem. It's a difficult issue to address.

Q. You don't want your staff to get assaulted. That's really what the issue is. You don't want the inmate patient to assault another inmate in that therapeutic group?

A. Yes. And, yet, there's a need for the inmate patient to have a therapeutic contact in an environment where there are other people present.

Now, this is an issue about which reasonable people and reasonable experts can disagree whether it can or should be [358] done in cages or not.

Dr. Metzner's contribution was to say if it's going to be done in these cages, the cages should be in a therapeutic context, should be of a particular kind. They should have a particular design.

If that's the way the department has decided to approach this, then this is what these exercise or these therapy cages ought to look like.

Those are not the cages. Those are not the cages that I saw in the units that were being used in administrative segregation units, in all of the prisons that I looked at that had ADSEG units. Those are not the kinds of cages we're talking about.

And I doubt very seriously—and, of course, Dr. Metzner can speak for himself—that he would approve of the kinds of cages that I saw in the administrative segregation units that I toured and about which I wrote in my report.

Q. Now, you wouldn't disagree, would you, that the use of therapeutic modules has been accepted as part of the court-approved revised program guide of 2006?

A. I think it's—I think it's contemplated in lieu of alternative approaches. But, again, we're talking—you're talking about this as an abstraction.

I'm talking about the reality of what those cages look like and where they are located, and what they are used [359] for.

Those are the issues about which I was concerned and about which I expressed myself in my report.

Q. And you don't dispute that in the 20th round monitoring report Special Master Lopes found that several California Department of Correction rehabilitation institutions were substantially compliant with the revised program guide and with court-ordered standards.

A. Special Master Lopes found a number of things. Ironically, one of the things that he was most concerned about and, in fact, one of the recommendations he made had to do with the use of these cages, had to do with the use of these cages as alternative placements in lieu of putting people in mental health crisis beds.

It's the third recommendation. He's concerned enough about it to recommend that the actual use of these things be very carefully documented.

Q. I'm just referencing, actually, page six of the 20th round monitoring report in the first introductory statement where it says:

> "Overall, the monitor's review found that several California Department of Corrections and Rehabilitation institutions were substantially compliant with program guide and court-ordered standards," correct?

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[362] The Witness: May I be released?

Judge Henderson: Oh, I'm sorry. Yes, you may be Released.

(Thereupon, a recess was taken.)

The Clerk: Please be seated.

Judge Henderson: okay. You may call your next witness, counsel.

Mr. Specter: okay, Your Honors. Plaintiffs call Jeanne Woodford.

(Thereupon, the witness was sworn.)

The clerk: state and spell your full name for the Record.

The witness: my name is Jeanne Woodford, J-E-A-N-N-E W-O-O-D-F-O-R-D

Thereupon—

Jeanne Woodford

Was called as a witness on behalf of the plaintiffs, and after having first duly sworn, was examined and testified as follows:

Direct examination

By Mr. Specter:

Q. Ms. Woodford, you were—you know these cases are both the Coleman and Plata cases, correct?

A. Yes, I'm aware of both cases.

Q. Part of the reason you're aware of both cases is that you were a defendant at one time; is that true?

[363] A. Yes, I was a defendant in both cases.

Q. And that's because you worked for the California Department of Corrections; is that right?

A. That is correct.

Q. For how long did you work for them?

A. I worked for the Department of Corrections for a little over 27 years.

Q. And is it true that you have—you worked your way up from a correctional counselor position at San Quentin to the Acting Secretary of the entire Department of Corrections?

A. I actually worked my way up from a correctional officer position at San Quentin into becoming the Acting Secretary of the California Department of Corrections and Rehabilitation.

Q. And so during—could you give us a little brief summary of that journey in terms of the positions you've held?

A. I started at San Quentin in June of 1978, two weeks after graduating from Sonoma state university with a degree in criminal justice.

I was a correctional officer for about five years. Then, I was a Correctional Counselor I, Correctional Counselor II, a Correctional Counselor III, a Program Administrator, a Correctional Captain, an Associate Warden, and then a Chief Deputy Warden until being appointed by Governor Davis in 1999 as a Warden at San Quentin.

I was the Warden at San Quentin until 2004 when [364] Governor Schwarzenegger appointed me Chief director California Department of Corrections. And then, about a year-and-a-half later in July of 2006, J was appointed as the undersecretary of the California Department of Corrections.

And during my time as the Undersecretary, the secretary stepped down, so I was the Acting Secretary for a short time.

Q. Great. And you left the Undersecretary's position in July of 2007 or six? Seven?

A. I think it was 2007. I'd have to look at my resume, but I believe it was July, 2007.

Q. And—

A. Actually, it was July, 2006. I'm sorry.

Q. Okay. So you were working at San Quentin in the early 1980's, were now not?

A. Yes, I was.

Q. And at that time you were not in a management position. You were working in the cellblocks; is that right?

A. That's correct.

Q. And you were familiar with a case called Toussaint?

A. I was very familiar with a case called Toussaint.

Q. And that was a case that arose out of a judgment of this court, the district court of California in the northern district?

A. That's correct.

[365] Q. Right. And in that case — well, during that time period did you see the population rise during your time at San Quentin in the early '80's?

A. Yes, I did. Actually, when I started at San Quentin there were cellblocks that were completely closed. And then, later we began to experience large number of inmates coming into the system as a result of a change in the sentencing laws in California.

Q. I see. And can you explain to the court what effects you saw from that increase in the population at San Quentin?

A. Well, when I first started at the prison it really reminded you of a college campus. You saw inmates traveling to school and going to their work assignments, carrying books.

There were very active programs going on involving inmates. Most of the inmates were single-celled. There was no idleness at all.

Within a very short amount of time, the determinate sentencing act began to send prisoners within the prison system.

So within a couple of years of me starting there, we started to receive more and more inmates into the system. And these were younger inmates who were serving sentences of 25 to life as a result of the change in the sentencing law.

So we were getting more and more people who were serving longer and longer sentences. And because the purpose of

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[366] Q. Now, later on after the Coleman and Plata cases were filed, and then judgments were entered, did you become familiar with those as part of your responsibilities as warden at San Quentin?

A. Yes, I became familiar with both Plata and Coleman as the warden at San Quentin.

Q. And can you explain to the court what difficulties, if any, there were you had at San Quentin in complying with those decrees and what the cause of those difficulties were?

A. Well, it was virtually impossible to comply with both of the decrees, and the difficulty was primarily because of the overcrowding at San Quentin.

And to describe it, I think you have to understand the three missions that San Quentin has. One being the reception center where at times we were receiving anywhere between 100 and 200 inmates a day.

So with that kind of intake into our—into San Quentin and with the kind of overcrowding you spent your day managing where to house people.

Medical staff due to vacancies and just the sheer numbers and lack of space were unable to keep up with physicals or providing any kind of chronic care follow-up at the reception center population.

Inmates in the reception center who were diagnosed as mentally ill, either as EOP's or triple CMS weren't receiving really any treatment beyond identifying that they were triple

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[376] many, many, many meetings with the variety of people trying to bring some solutions to the Department of Corrections.

Q. And so, given all that effort both on a institution management institution level and on the headquarters level as a high level manager, given all that experience and your experience with the Department of Corrections, what do you think was the primary cause of the inability to provide healthcare to prisoners?

A. I absolutely believe the primary cause is overcrowding, because we would come up with wonderful ideas and have great planning, but overcrowding interfered with our ability to implement any of those ideas, to bring resolution to any of the problems that we're facing in both of those lawsuits.

And the overcrowding was every day, more and more inmates coming into the system.

Q. And when you're at the headquarters did you express that conviction to any of your superiors?

A. Yes.

Q. And who would you talk to about that?

A. Well, I would talk to—well, as the Director I would talk to the undersecretary and secretary about that. Then, when I was the undersecretary and acting secretary I talked to the governor's staff about the overcrowded conditions and that we needed to address overcrowding in order for us to be successful at any of the efforts we were trying to do, including providing [377] medical care, mental healthcare and rehabilitative services to inmates.

Judge Henderson: can I interrupt you?

Mr. Specter: sure.

Judge Henderson: I want to make sure I have this timeline. You talked almost longingly about the good old days at San Quentin when there was not overcrowding. That's my characterization.

And you now are talking about the overcrowding. Would it be fair to say that in those days of yor, I don't know if there were medical inadequacies, but would you, if you were asked then "are they solvable" because there's not overcrowding, would it have been your view looking back that they are solvable and that because of the overcrowding they are no longer solvable?

Is that a fair summation?

The Witness: Yes, Your Honor. That's a very fair summation.

Judge Reinhardt: you got up to when you were undersecretary. When you were acting secretary to whom did you talk? Who were your superiors then?

The Witness: Well, I worked for the governor, but I did not get to have a conversation with the governor until my last day when I stepped down as secretary.

So I was talking to his chief of staff and the cabinet secretary and his legal

* * *

[380] Q. And I'm going to refer you to the picture that's on screen that's Plaintiff's Exhibit 345. Could you describe what you see there, please?

A. I see a picture of what looks like a gymnasium with triple bunks. Looks like it's severely overcrowded.

Looks like there's barely room between the bunks. And it also looks like it's crowded to the point inmates are expected to be on their bunks.

Q. And from a corrections administrator's perspective do you see any problems with that housing arrangement?

A. I absolutely see many problems, and I've seen scenes like this all over the department as the director and undersecretary of the Department of Corrections, and in my own experience as the warden at San Quentin, overcrowding inmates into the gymnasium there.

It's very difficult to have of good lines of sight of the inmates. It's very difficult to know who the inmates are in these crowded situations.

I think it's really hard on the inmates when there isn't room for them to move around at all, and they spend the majority of their day on or near their bunks. You end up with violence breaking out in these situations.

I've personally experienced more than one riot at San Quentin, and I know that occurs around the Department of Corrections. And, you know, staff, many staff don't feel even [381] comfortable walking around units like this because they are so overcrowded, and so it's very hard on inmates who are more vulnerable.

And it's really difficult to know often if there's medical issues and particularly mental health issues when you're this crowded and you're not having that constant conversation and contact with the inmates as a staff person.

Q. And when you took a tour in August of 2008, did you see units where or had you heard about incidents where there weren't enough staff on the unit?

A. Yes, I heard that when I was at Lancaster.

By the way, when we walked in the—when I walked in the gym at Lancaster—I don't know if it was this gym, but a gym like this—there was only one officer there. And she told me that there was a second officer assigned there, but he was out escorting inmates.

So this clearly was a situation where there wasn't enough staff in the unit to even attempt to walk around in a building this crowded.

But in another case, we were in an EOP unit, and I believe it was an EOP unit at Lancaster. And the staff told us that the day before they were so short of staff that there was no staff on the floor.

And that the one staff member that was assigned to the unit had to go up to the control booth and monitor the [382] inmates from the control booth.

And during that time, an inmate had a medical emergency, injured his foot in his cell. And the inmate had to get the attention of the staff in the control booth. And without anyone talking to him on the floor, they opened the door. The inmate told the staff that he'd injured himself, and the staff said:

"Are you able to get over to the CTC on your own?"

And he said: "I think so."

And they let him out of the unit without anybody doing a physical check of the inmate.

Q. And while you were in the department, was there an incident at the California Rehabilitation Center involving inmate death in a gym that was noteworthy?

A. Yes. While I was—I believe I was the director. I may have been the undersecretary. But I think I was the director. There was a death in a crowded gym at CRC that went on. It was a homicide of an inmate, and it went unnoticed by staff for several hours.

An investigation was actually opened up of that case, and I'm sorry I don't know the outcome of the investigation. But clearly it's very difficult to observe inmates appropriately in overcrowded situations like this.

[383] And you can have medical emergencies that go unnoticed by staff and can end up in death, as the case was at CRC.

Q. So did the tours—what effect, if any, did the tours have on your thoughts about overcrowding affecting the ability of the department to provide adequate healthcare?

A. I'm still convinced that overcrowding is a primary issue that inhibits the department from being successful at providing both healthcare or mental healthcare for inmates that are in the Department of Corrections and Rehabilitation.

Q. In his deposition, Matt Cate testified that overcrowding makes all the operations of a prison more difficult, he said, including medical and mental healthcare. Do you agree with that statement?

A. I absolutely agree with secretary Cate. Running a prison is a coordinated effort. In addition to providing mental healthcare and medical care inmates have to be taken to the dining hall to be fed. They need to have the appropriate amount of exercise.

They need to be involved in programs. And all of that has to be done within a short amount of time because most prisons run their operations during daylight hours, especially the higher security ones.

The more overcrowded you are, the more difficult it is to meet the basic, basic needs of inmates.

And it even gets to be impossible to get to them [384] their mental health treatment and healthcare exams when you're trying to do just basic operations in an overcrowded setting.

Q. In terms of inmate well-being, prisoner well-being and the safety of prisoners, how should a prison system really be functioning?

A. Well, I think it's the responsibility of prison administrators to design a system that allows inmates to have an appropriate living environment, a system that provides prevention of medical problems, and that doesn't have a situation where inmates decompensate mentally.

We need to treat people humanely. You know, I think the most glaring example is the reception centers where such a large percent of our population is. About 25 percent of the inmate population is in reception centers, and in those reception centers when you have people housed in bunks like this (indicating).

We are paroling a large number of inmates every week. San Quentin over 200 a week are paroled out of a situation like this (indicating).

I think just any correctional administrator would say that this is absolutely inappropriate to house human beings in this kind of situation and return them back to our society where mentally they are no better off, and probably in worse shape and in situations like this where we have done nothing to assist with their medical treatment in a way that would be considered [385] appropriate.

Q. And is it—just two more questions.

Is it your opinion that without a reduction in overcrowding that the Department of Corrections will be unable to provide adequate medical and mental healthcare?

A. It's absolutely my opinion. And without addressing the issue of overcrowding, the Department of Corrections will never be able to provide appropriate medical or mental healthcare and sustain—sustain any kind of quality constitutionally-adequate medical or mental healthcare. Medical or mental healthcare.

Q. And two more questions, Ms. Woodford.

First, how much are you getting paid to be here today?

A. I'm not being paid to be here today.

Q. So you did all these tours and review of the documents for free, basically? And why did you do that?

A. I did it for free because I truly believe that we can do better than we are in California. I think it's unbelievable that in this state that we have the kind of overcrowded conditions that we have; that we do little or nothing to prepare people for the return to society in spite of the fact that we parole 10,000 people a month from our prison system.

And I absolutely believe that we make people worse, and that we are not meeting public safety by the way we treat people.

[386] And that I believe overcrowding is prohibiting us from providing quality medical care and mental healthcare to inmates in our system.

And for California to be in the shape that it's in is just unbelievable. I mean, we just recently passed an initiative that gives chickens appropriate living space, and yet we have prisons that look like this (indicating).

Mr. Specter: No further questions, Your Honor.

Judge Henderson: Does CCPOA have any questions?

Ms. Leonard: No further questions of this witness, Your Honor.

The Court: All right.

Cross-examination?

Mr. Mello: Good afternoon. Paul Mello for Defendants.

Cross-examination

By Mr. Mello:

Q. Good afternoon, Ms. Woodford.

A. Hi.

Q. When was the last time you worked in San Quentin Prison?

A. It's been about three years. Well, I left there in February of 2004.

Q. Okay.

A. So it's been four years.

Q. Four years. Almost five?

* * * *

[388] Death at CRC. What year was that?

A. It was either 2005 or 2006. I'm not sure about the year.

Q. And I want to now ask you questions about your November, 2007 report. Now, I'm going to ask you to go to page two, paragraph six of that report.

And in your report you opined that overcrowding is the primary cause of the constitutional violations in the *Plata* and *Coleman* cases, correct?

And I believe I've also got it on the screen to your Right.

A. Yes.

Q. Okay. In forming the opinions expressed in your November, 2007 report you did not read any of the *Plata* receiver's reports or plan of action, correct?

A. I'm sorry. I didn't hear the first part of your question.

Q. Sure. In forming your opinions expressed in your November, 2007 report, you did not read any of the receiver's reports or his plan of action, right?

A. That's correct.

Q. Okay. In forming your opinions in your November, 2007 report, you had not visited any CDCR prisons since the middle of 2006, correct?

A. No, but I did read the service plan of action and reports for my supplemental, and I did visit prisons for my supplemental report.

[389] Q. And I was asking you specifically about your November, 2007 report.

And my question is: at the time that you were forming the opinions expressed in your November, 2007 report you had not visited a single CDCR institution since at least the middle of 2006. That's true, right?

A. That is true.

Q. In forming the opinions expressed in your number of 2007 report, you did not know whether there had been any improvements in the delivery of medical care or mental healthcare since you left CDCR, right?

A. That's correct.

Q. In forming the opinions expressed in your November, 2007 report, you did not know if there were more or fewer correctional officers since you left the department in 2006, correct?

A. No, I think I had—as I recall, I did know that the department was still down many correctional officers at that time.

Q. I'm sorry?

A. I believe that I knew the department was still down many correctional officers at that time.

Q. But did you know whether or not there were more officers or less officers than when you left the department?

A. No, I did not know that.

[390] Q. And in forming the opinions expressed in your November, 2007 report, you did not know whether there were more clinicians providing medical or mental healthcare since you left the department in 2006, correct?

A. I believe that's correct.

Q. Before signing your November 7, 2000--2000—

Mr. Mello: Strike that.

By Mr. Mello:

Q. Before signing your November, 2007 report, you did not review any documents that listed the amount of clinical space in California's prisons, did you?

A. Not that I recall.

Q. Okay. In forming the opinions expressed in your November, 2007 report, you did not know the status of the delivery of medical and mental healthcare at each of the 33 prisons, correct?

A. I did not know the current status at the time that I signed it, but I will say that I had not been gone from the department very long at that point, either.

Q. Right. I mean, the evidence will show that you were gone between sometime in 2006 and sometime in 2007. That's undisputed, right?

A. Yes, that's correct.

Q. The first draft of your November, 2007 report was prepared and made available to you on an internet site by Plaintiffs' [391] Counsel, correct?

A. That's correct.

Q. You did not handwrite your report, correct?

A. No, I assisted in preparing the report, but I did not handwrite it, that's correct.

Q. The first time you saw your report was when you viewed it on an internet site, correct?

A. The first time I saw it typed is when I reviewed it on the internet site, that's correct.

Q. Did you ever see it in some other form than typed prior to looking at it on the internet site provided you to by Plaintiffs' counsel?

A. No, I did not see it in written form. I had discussions, obviously, with the Prison Law Office in preparing the report.

Q. On page four of your November, 2007 report at paragraph 11, you wrote that:

> "CDCR lacks a sufficient number of personnel who have the necessary skill and training to manage such a large complex organization," end quote.

A. Yes.

Q. When preparing your report, the November, 2007 report, you did not know the existing physician-to-inmate ratio at CDCR, did you?

A. Did you say "physician-to-inmate ratio"?

Q. Yes, I did.

[392] A. No, I did not.

Q. Did you know the clinician-to-inmate ratio with respect to mental healthcare at that time?

A. No, I did not.

Q. When preparing your November, 2007 report you did not know the existing vacancy rate at any of the institutions, all 33 of them, with respect to physicians, nurse practitioners, physicians' assistants, RN's, LVN's psychiatrists or psychologists, did you?

A. I did not know specific numbers, but I did know that there was still a problem in filling positions.

Q. Did you note that problem, even a range, anywhere in your November, 2007 report?

A. Not that I recall.

Q. On page five of your report at paragraph 13, you wrote that:

> "crowding causes delays in moving reception Center prisoners to other prisons for treatment."

When you prepared your report you did not know whether crowding had caused delays in moving of reception center prisoners to other prisons for treatment since you left the department, correct?

A. I did not know specific examples, but I believe I knew that it was still a problem moving inmates out of reception centers just because I keep in contact with people who work in the department.

* * * *

[394] By Mr. Mello:

Q. On page seven, paragraph 19 of your November, 2007 report, you wrote that officers who are pardon?

Judge Reinhardt: May I ask you one question?

Mr. Mello: Sure.

Judge Reinhardt: About the problem with the dates, you're not questioning the accuracy of the witness's statements as of the year earlier. You're asking whether she knew of any changes between the time she left when she knew all these things, and one year later.

Mr. Mello: Well, I don't believe that Plaintiffs have established that she knew all those things with any specificity in 2006 when she left the department.

Judge Reinhardt: Well, your only question here about whether she knew anything a year later—

Mr. Mello: Correct. I am questioning when she—

Judge Reinhardt: Can I ask you a question?

Mr. Mello: I'm sorry. Yes.

Judge Reinhardt: What date do you think is relevant for our job in phase I to determine what the primary cause of the health and mental health violations was when the two findings were made?

Mr. Mello: I believe this court—and I haven't spoken with my co-counsel. But I believe this court established a cutoff that the relevant date was the end of August, 2008.

[395] Judge Reinhardt: No. No, for evidence. But as to the phase I issue, what was the primary cause or is the primary cause of the violations that were found in *Plata* and *Coleman*?

What do you think the court needs to establish what the primary cause is as of 2008 as of date the findings were made? What is your position with respect—

Mr. Mello: I believe that the PLRA is written in the present tense with respect to this issue. And I believe that current conditions are what are relevant.

I believe this court has told us that we cannot argue about whether we are currently in constitutional compliance. But I believe that the current conditions, the statute is written in the present tense, I believe. And I believe that current conditions are those items that are relevant to this judges' determination of whether or not Plaintiffs can show by clear and convincing evidence that overcrowding is the primary cause of the alleged deficiencies right now in CDCR's medical and mental healthcare systems.

And I believe that the current status is probably the most important thing, as opposed to something that she recalls when she was a warden back at San Quentin years ago.

I believe that's important. I believe that the evidence already to date has shown that there have been increases in many, many things, both in mental health and in medical care.

[396] And I believe those go to the fact that while we can't put on evidence that current constitutional compliance is met, that that overcrowding is not the primary barrier.

Judge Reinhardt: Well, she's saying, I gather, that the constitutional violation had to exist for Phase I purposes; that what is relevant is whether there's a constitutional violation today, not whether there was when the findings were made by the court. That's really irrelevant. It's only whether there's a constitutional violation today.

Mr. Mello: I don't believe it's irrelevant, but I do believe what is relevant is the current conditions in the system.

And I believe the evidence has shown and will continue to show that that current evidence doesn't show that overcrowding is the primary barrier to the unconstitutional delivery of medical and mental healthcare.

Judge Reinhardt: Okay. Thank you.

Mr. Mello: I've completely forgotten where I am. I usually—

Judge Reinhardt: you were in about 2006 or—

Mr. Mello: I'm pretty sure I was in 2008.

Judge Reinhardt: That's the supplemental report. Mr. Mello: oh, you are right. I was in 2007. Thank you, Your Honor.

* * * *

[405] A. Okay. I see that.

Q. Okay. And I asked you:

> "would you agree that the provision of housing is different from the provision of medical and mental healthcare?"

A. Again, I want to be sure that we're talking about the same thing. So could you explain what you mean by that?

Judge Reinhardt: I don't understand the question myself.

Mr. Mello: Okay.

Judge Reinhardt: Obviously, providing housing is different from providing medical care.

Mr. Mello: Okay.

Judge Reinhardt: But where does that lead us?

Mr. Mello: Understood. And I'll withdraw the question. How's that?

Judge Reinhardt: Okay.

By Mr. Mello:

Q. In your opinion, if the adult population in California's institutions was decreased by 40,000 inmates tomorrow and nothing else was done, the CDCR would not be able to provide constitutionally-adequate medical or mental healthcare to its inmates, would it?

A. If the population were reduced and nothing else was done, meaning that we didn't hire the appropriate medical staff and [406] provide appropriate medical facilities and all that, then I would agree you still would not meet a constitutional level of care.

Q. And in your opinion, even if CDCR released up to 40,000 of the most physically sick and most acutely mentally ill inmates over a period of time at the end of that period CDCR would not have a constitutionally-adequate medical and mental health-care system unless it also addressed other problems, such as access to care—healthcare records, information technology, continuity of care, just to name a few, correct?

A. Medication management and many other provisions of healthcare, yes.

Q. Correct?

A. Correct.

Mr. Mello: Nothing further.

Thank you.

The Witness: Thank you.

Judge Henderson: Any other Defendants or Intervenors?

Ms. Wang: The Defendant Intervenors have no further questions, Your Honor.

Judge Henderson: Thank you, counsel.

Redirect?

REDIRECT EXAMINATION

* * * *

Vol 3

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UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

NO. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

TRANSCRIPT OF PROCEEDINGS

San Francisco, California
Thursday, November 20, 2008

* * * *

[420] PROCEEDINGS

November 20, 2008 9:15 o'clock a.m.

The Clerk: Please be seated.

Judge Henderson: Okay. Good morning, counsel. You May call your first witness when you're ready.

Ms. Hardy: Good morning, Your Honors. Alison Hardy for the Plaintiffs. And Plaintiffs call Dr. Ronald M. Shansky.

The Clerk: Please raise your right hand.

(Thereupon, the Witness was sworn.)

The Clerk: Please state and spell your full name for the record.

The Witness: My name is Ronald Mark Shansky, S-H-A-N, as in Nancy, S-K-Y.

Thereupon—

Dr. Ronald Mark Shansky was called as a witness on behalf of the Plaintiffs, and after having been first duly sworn, was examined and testified as follows:

Direct examination

By Ms. Hardy:

Q. Good morning, Dr. Shansky.

A. Good morning.

Q. You're a board certified physician in internal medicine and in quality assurance; isn't that right?

[421] A. That's correct.

Q. And you've been a physician for over 30 years?

A. Yes.

Q. And the focus of your practice over the course of three decades has been on correctional medicine; isn't that right?

A. That's correct.

Q. And you started your career as a physician right out of residency at the federal jail in Chicago?

A. Yes. That was my first correctional healthcare work.

Q. And then—and how long did you do that job?

A. Seven years.

Q. And then, in 1982, you became the medical Director of the Illinois State Prison System; is that right?

A. That's correct.

Q. And you did that job for how long?

A. For 11 years.

Q. And then, so you left in '93, but you returned in '98. Why was that?

A. There was a new director of corrections, and he called me and asked me if I would serve. And I said I was finishing out my receivership, and so I could only fill that capacity on a part-time basis. But he said that was good enough, and so I came back for a year on a part-time basis.

Q. And since you left the Department of Corrections in Illinois you've been a correctional healthcare consultant; is that right?

[422] A. That's correct.

Q. And over the course of your entire career, you've consulted with more than two dozens correctional agencies on healthcare issues; is that right?

A. More than how many?

Q. Two dozen?

A. Approximately.

Q. Okay. And that's been both domestically and internationally; is that right?

A. A few internationally.

Q. And in the course of your career you have been to well over a hundred prisons to specifically—specifically for the purpose of reviewing healthcare in those facilities; is that right?

A. Both prisons and jails.

Q. Additionally, courts have appointed you in different cases in various capacities; is that right?

A. That's correct.

Q. And in what capacities have you served?

A. Well, I've been appointed as a special master, as a court-appointed expert, as a special monitor, as a receiver in the case of the D.C., Washington D.C. jail.

Q. And you've also edited a book on correctional medicine; is that right?

A. I was one of the associate editors of the two editions of [423] *Clinical Practice of Correctional Medicine*.

Q. And you consider yourself an expert on correctional healthcare, don't you?

A. Yes.

Q. You're aware that the *Plata* court has found the medical care in the CDR violates the constitution; is that right?

A. Yes.

Q. And in your opinion, what is the cause for the constitutionally inadequate medical care?

A. From my tours and my review of the documents, I would say overcrowding is the primary cause of the ongoing inability to meet constitutional levels of care.

Q. Doctor, how certain are you of that opinion?

A. I'm confident in it.

Q. Okay. You toured nine prisons, CDCR prisons in the last 13 months; is that right?

A. That's correct.

Q. And did your observations on these tours provide a basis for your opinion?

A. Yes.

Q. And what did you observe on these tours?

A. Well, there were a variety of problems related to inadequate physical environment, impacting on process of care, beginning with the reception process and ability to perform a comprehensive exam on intake.

[424] There were problems with access to care in terms of lack of officers, especially during lockdown periods, and therefore scheduled visits didn't occur anywhere near the rate that they did usually.

There were problems with medical records, documents not being filed; documents being very difficult to locate; the medical records quite disorganized, which inhibits doctors to have a sound foundation of the facts with a given patient.

There were a variety of those kinds of things we identified.

Q. And when you toured prisons, you reviewed healthcare—or, sorry, I mean health records specifically, a sample of them, didn't you?

A. Yes. We reviewed records at each of the facilities.

Q. And what did you find in those records, specifically?

A. Well, I was looking at the—I was focusing on these reviews on the ability of the program to provide necessary follow-up and continuity for individuals whose problems were serious enough to cause them to be sent offsite, either on a scheduled basis for a consultation or a CT exam or an MRI, or on an unscheduled basis, that is, on the basis of an emergency problem.

And what we found was in a significant portion of the cases we reviewed, there was an absence of documents from the offsite provider. So even though the patient went offsite, the [425] Consultation report wasn't there. The CT report wasn't there. The MRI report wasn't there.

And there were other instances when reports had been filed, but no one had actually seen them, initialed them and acted on them.

There were also instances in which when the reports were there, there was no follow-up when the patient returned to—sorry.

Judge Karlton: Not your fault. Nobody knows why that happens.

The Witness: Okay. There were many instances in which the follow-up aspect of care was not provided. And that was in a significant portion of the records at virtually all the facilities we went to.

In fact, the policies of the CDCR require, are designed to facilitate continuity, and yet the programs were not yet able to not only comply with the policies, but ensure the continuity of care that is required for adequate services.

By Ms. Hardy:

Q. And given that lack of continuity, is there a risk of harm to the patient?

A. Absolutely. There's unquestionably a risk.

Q. On your prison tours you spoke with prison clinicians and with prison administrators, correct?

A. Yes

[426] Q. And did they tell you how overcrowding was impacting their operations?

A. Yes, they described their inability to ensure that patients were seen timely, both for services provided on-site and for scheduling and obtaining services offsite.

Q. And did they describe how the impact of the available clinical space affected their ability to deliver care?

A. Yes, there were at least a few, if not more, that indicated that one of the major inhibiting factors as they have added additional staff was their inability to maximally utilize the staff because of the inadequate space arrangements.

Q. Were the findings that you made on these prison tours consistent with other documents you reviewed in this case?

A. Yes, particularly documents that were produced by the Receiver's office. It's really consistent with the governor's statement and consistent with the recent death review document.

Q. So you reviewed the receiver's 2007 prisoner death report; is that right?

A. Yes.

Q. And in that report, that death review committee divides the deaths in preventable, possibly preventable and nonpreventable deaths, correct?

A. Correct.

Q. And you're familiar with those terms, right?

A. Yes.

[427] Q. In your experience as a physician have you done death reviews?

A. Yes.

Q. And is it your experience that physicians are reluctant or liberal in attributing preventability to a patient death?

A. In my experience—and I have done death reviews. Not only did I do all of them in the Illinois system from 1982 to 1993, but also in my travels around the country I have participated in death reviews with colleagues from different systems.

And I do think the attribution of "preventable" is something that doctors are reluctant to do frequently, because I believe it, in their mind, may connote a clinician responsibility for the death. And so there is unquestionably a reluctance to do that.

And, therefore, I think that's what made people more comfortable with the category of "possibly preventable."

Q. Does your review of the report affect or impact your opinion that crowding is the primary cause of the constitutional violations in the CDCR?

A. My review of the report buttresses my view of that. It is particularly buttressed by when you look at the types of lapses in care which were extreme departures from the standard of care, there are several that clearly are a consequence of overcrowding.

Things like delay in access, failure to adequately [428] pursue abnormal test results, failure of provider-to-provider communication, medication delivery problems, medication prescribing errors. There's a series of items which clearly can result from overcrowding.

Q. For the 395 cases that are reviewed in that death review report, there were 292 extreme departures from the community standard of care identified; is that correct?

A. That's correct.

Q. Were you surprised to see this number of lapses in a sample of this size?

A. Well, the fact that the lapses occurred in almost 60 percent of the cases, yes, because when I reviewed—and my policy that I promulgated I had to review every death in the Illinois system. And where there was an extreme lapse I would make it clear to the director of corrections.

We would see five, maybe ten percent of the deaths in which there was an extreme departure from the standard of care.

Judge Karlton: What was the percentage for California that you were looking at?

The Witness: About a little less than 60 percent of the total cases, including preventable and nonpreventable.

By Ms. Hardy:

Q. Did you look at the rate of deaths that were preventable or possibly preventable from the 110 deaths that were cosidered natural and unexpected?

[429] A. Yes.

Q. And what did you conclude from that?

A. If you do the math, out of 110 there were 44 that were possibly preventable or preventable. So you're looking at a 40 percent rate of the natural, unexpected deaths that were either possibly preventable or preventable. And that's extremely high.

Judge Reinhardt: Over what period of time?

The Witness: This is the calendar year, I believe, 2007.

By Ms. Hardy:

Q. And then, you also looked at the deaths for the 328 deaths that occurred because of illness, both expected and unexpected. And what proportion of those were cosidered preventable or possibly preventable?

A. About 20 percent, as I recall.

Q. And compared to other settings that you've worked in, do you believe that those rates are high?

A. Yes.

Q. And compared both to the Illinois setting are there other settings that—

A. Well, states, for obvious reasons, don't necessarily publish this type of data. But, in my experience of reviewing records with systems over the course of the last few decades, that rate seems to be quite high.

[430] Judge Karlton: May I inquire? You indicated that states ordinarily don't publish this kind of data. Is there any state at all that you are aware of that attempts to distinguish between preventable and unpreventable.

The Witness: I believe many systems do that, but they do not publish it. Concerns about litigation.

Judge Karlton: I see.

By Ms. Hardy:

Q. Based on the number of lapses that you saw in this cohort of 395 deaths in which there were 292 extreme departures from the community standard of care, do you believe that the extreme departures are limited and occurring only in the cases of patients who die?

A. Oh, no, absolutely not. When you look at these—at this report you can see that extreme lapses can occur even in a death case, but it doesn't necessarily contribute to the death.

On the other hand, extreme lapses can contribute to delays in diagnosis and treatment, can contribute to avoidable emergency room trips, can contribute to avoidable hospitalizations.

So, I don't think there's any question from reviewing this data you would have to believe that these lapses are pretty widespread at this point.

Q. And you believe that the lapses that were identified appear to be systemic or individual care lapses?

[431] A. Well, lapses can be a mixture of both. But clearly several of these point to systemic issues related to crowding unquestionably.

Q. You're aware that the receiver has hired quite a few nurses and also hired physicians; is that right?

A. Yes.

Q. Does this change your opinion that crowding is causing the constitutional medical problems?

A. No. Again, it buttresses it. At the beginning of—well, somewhere in the midst of the *Plata* case, I had a discussion with Judge Henderson about his concerns about the quality of physicians and his desire and intent to do something about that issue since that was an issue that one might characterize in a certain sense as "low-hanging fruit."

You could intervene on that with the tools of the court. And as a result, impact things like death rates and severe negative outcomes. Ultimately, then, things changed. It became a full receivership.

But there's no question that, a: the quality of clinical providers was clearly known to Judge Henderson whenever that was, two or three years ago, and a major concern.

And it's clear, again, from the receiver's documents that they believe the major contributing factor to the decrease in death rate is related to the increase in quality and quantity of clinical staff.

[432] Q. Why not then let the receiver just go ahead and fix the problem?

A. Well, in my view—and I draw—I guess there's no way of avoiding it—from my experience when I was appointed the receiver at the D.C. jail.

I was the first receiver of a correctional healthcare program, and I had obviously a steep learning curve.

I didn't appreciate that at the D.C. jail at the time I was appointed receiver the jail was already under a population cap, and the population had been substantially reduced—I think it was two or three years—before my appointment.

And when I came on as the receiver, I, therefore, had the advantage of being able to put together a brand new system, in a sense, into an environment that was not suffering the stresses of overcrowding.

And I didn't appreciate it then because the only thing I knew was that situation which I had been appointed to.

But it's clear to me now that that gave me a tremendous advantage over what the receiver is trying to do here in California.

Q. And that advantage was?

A. Well, that advantage is when you're trying to create a new system in the midst of overcrowding, which stresses every aspect, environmental resources, infrastructure systems, medical records, tracking, scheduling, quality and quantity of staff, [433] the environment in which those staff are going to be attempted to be retained once they are hired, that dramatically reduces your ability to bring a system into compliance.

And what it does is it—if the system can be brought into compliance under the conditions of overcrowding, at a minimum that is going to delay the time frame that that's achievable for a lengthy period of time, which just extends the period of avoidable suffering, hospitalizations and death.

Q. Thank you, Dr. Shansky.

Judge Henderson: Thank you.

CCPOA wish to question this witness?

Mr. Leonard: No further questions.

Judge Henderson: Okay.

Cross-examination.

Cross-examination

By Mr. Mello:

Q. Good morning, Dr. Shansky.

A. Good morning, Mr. Mello.

Q. In your opinion is the California prison system overpopulated today?

A. Yes.

Q. And population and percentage of over design capacity vary between prisons in the system, correct?

A. That's correct.

Q. And, in fact, some segments or units in prisons are less

* * * *

[438] accessible from the prisoners' bathroom and shower area.

Do you remember?

A. Yes, if I could have a second I'll find my—

Q. Sure.

We've put it on your screen for you to your right, too, doctor. So either way.

A. All right. Give me a second here.

Okay. Now, what page?

Q. Page six, paragraph 16.

A. Page six.

And paragraph 16, you said?

Q. Yes.

A. Okay.

Q. And you're talking about that exam room.

A. Yes.

Q. That it was only accessible from the bathroom. Do you remember that?

A. Yes. Yes.

Q. In and of itself, the location of that exam room was not the cause of constitutionally-inadequate healthcare in your opinion, was it?

A. You mean, throughout the system?

You're talking about—

Q. I'll ask it again. I'll ask the question again.

A. Okay.

[439] Q. In and of itself, the location of the exam room was not a cause of constitutionally-adequate (sic) medical care in your opinion at that facility?

Judge Karlton: That facility.

The Witness: Constitutionally inadequate, you're saying.

By Mr. Mello:

Q. Right.

A. No. Taken in isolation, that, in itself, wouldn't necessarily always correlate with unconstitutional care.

Q. And, in fact, it's your opinion that Constitutionally-adequate medical care could be provided in that unusual setting if Plaintiffs were seen timely and with appropriate assessment and followthrough, correct?

A. Correct.

Q. And in your opinion in even very odd settings constitutionally-adequate medical care can be delivered if patients are seen with timely and appropriate assessment and follow through, correct?

A. Yes.

Q. It's fair to say based upon your tours at the various prisons that the level of medical care being provided in CDCR's prisons varies from unit to unit within different prisons in California's system, correct?

A. Yes.

[440] Q. In preparing your first report in November, 2007—and let me just stop. Are you having a hard time hearing me?

A. Sometimes. The acoustics are not great.

Mr. Specter: We are having a hard time.

Mr. Mello: I don't care about you guys.

The Witness: Go ahead.

By Mr. Mello:

Q. Okay. Sorry, doctor. If I could just wall off— Okay.

In preparing your November, 2007 report, you reviewed letters prepared by Plaintiffs' counsel following tours that they had done of various institutions, correct?

A. That's correct.

Q. And you also reviewed those post-tour letters in preparing your September, 2008 report, correct?

A. Yes.

Q. In your—on page 15 of your September, 2008 report, you discuss mule creek state prison.

A. Yes.

Q. Okay. And in preparing that report, you looked at CDCR's weekly population report for August 20, 2008, correct?

A. I honestly don't remember. It may have been.

Q. I think it might refresh your recollection if you look at that page.

Let me just back up and try to speed it up here. Did you understand that mule creek state prison was over 215 percent [441] of design bed capacity?

A. Yes.

Q. Okay. So in your opinion, mule creek was severely overcrowded?

A. Yes.

Q. Are you aware that Plaintiffs' counsel, Mr. Fama, prepared a post-tour report following his tour of mule creek state prison on March 4th and 5th of 2008?

A. Yes.

Q. Okay. And we spoke about that at your deposition on that Saturday in Chicago, right?

A. Yes. Yes.

Q. And that's Defendants' exhibit 1084, page two. And I'll pull it up, and it will be on the screen there.

A. Do you have a—

Q. It will be on the screen, and he'll blow it up for you. Okay?

And in that report, it reads that:

> "Mule Creek State Prison's compliance with key access to care time frame requirements, including for registered nurse triage and pcp appointments, including chronic care as well as for specialty care is generally very good at present time."

Do you see that?

A. Yes.

[442] Q. And it goes on to say:

> "certain exceptions are mentioned below. This is due to, among other things, diligent efforts by staff, including the schedulers, a relatively large number of PCP's allowing at times for the sche-

duling of double PCP lines in clinics and the low vacancy rate among RN's," correct?

A. Yes.

Q. In your opinion from this summary it appears that access to needed medical care can be provided in even severely overcrowded conditions, correct?

A. According to that. When I do my reviews, I generally use a combination of exactly that type of scheduling information with a selected record sample, which is the verification methodology.

Q. Okay.

A. And I don't know if Mr. Fama used the record methodology.

Q. Okay. Do you have any reason to believe he did or did not?

A. I have no idea.

Q. Okay.

Since the *Plata* receiver was appointed in April, 2006, in your opinion there have been numerous improvements in the delivery of medical care in the prisons, correct?

A. That's my understanding, yes.

Q. And there have been improvements in the delivery of medical care in California prisons at the time you signed your November, [443] 2007 report, correct?

A. Yes.

Q. The post-tour letters prepared by Plaintiffs' counsel which you reviewed in connection with preparing your November, 2007 report, documented some of those improvements, correct?

A. Yes.

Q. And in their post-tour letters Plaintiffs documented responsiveness to appeals, timeliness of appointments?

A. Where are you referring to now?

Q. I can take you to your deposition, if you want.

Let me ask you a question.

A. Okay. It would be helpful, because I'm not sure—

Q. Okay. Let me ask the question, and then you can tell me if you need your recollection refreshed.

A. Okay.

Q. In their post-tour letters that you reviewed in preparation of your reports in this case, Plaintiffs' counsel documented numerous improvements in responsiveness and appeals, timeliness of appointments and filling of clinical positions, correct?

Do you remember testifying to that?

A. I May have. I would really prefer seeing the deposition.

Q. Okay. Sure.

Mr. Mello: Let's pull up day one of his deposition.

The Witness: Now, which deposition was this?

[444] By Mr. Mello:

Q. Last December.

A. Well, the first?

Q. Yes.

A. The first deposition, Okay.

Q. Page 70, line 25 through 71, line nine, please.

Ms. Hardy: Which deposition?

Mr. Mello: December.

The Witness: Okay. I see line nine.

By Mr. Mello:

Q. Okay. Do you want to look at those lines that I just mentioned to see if it refreshes your recollection?

A. Lines nine through?

Q. I'm sorry. I think I said lines—

Judge Reinhardt: three through nine.

By Mr. Mello:

Q. Page 70. 70, line 25.

A. 25, Okay.

Q. Through page 71, line nine.

A. Okay.

Judge Karlton: That's not what you've got up.

Mr. Mello: Pardon me?

Judge Karlton: I say currently that's not what you've got up.

Or is it? Maybe it is.

[445] The Witness: 25 begins with:

> "do you recall as you sit here today any of the improvements that were identified in any of those post-tour letters?"

Judge Karlton: Oh, I see.

By Mr. Mello:

Q. Right. And then, what did you answer?

A. Yes, I—what I stated was:

> "there were—and I can't remember by facility—but there were improvements with regard to responsiveness in appeals. There were improvements with regard to timeliness of appointments in some instances. There were improvements in some instances with regard to staffing, you know, filling positions, those kinds of things."

Q. And you believe that to be accurate?

A. Yes.

Q. Okay. And true, to the extent they are different. Now, that' my—i'll withdraw that question.

A. Okay.

Q. In November, 2007 you said at the time you signed that report you were aware that the number of board-certified, board-eligible physicians had increased, correct?

A. Yes.

Q. In your opinion, improved credentials of physicians [446] generally means improved competence, correct?

A. Correct.

Q. Other improvements that you have observed include an improvement in nurse staffing filled positions, correct?

A. Correct.

Q. You are aware—because you were asked about it at your deposition, I believe—but you are aware that the receiver has reported that the goal of filling 90 percent of registered nurse positions has been achieved at 22 institutions, correct?

A. I know they are very close. I forget what the total was, but that sounds about right.

Q. And does it also sound about right that systemwide he was within 2 percent of his stated goal of filling 90 percent of nursing positions?

A. Excuse me. Is that in one of the recent staffing reports they produced?

Q. Yes.

My question is: do you believe that to be true or Not?

A. If it's in the their report, I believe it to be true.

Judge Karlton: The question is whether you yourself believe it. And you don't know; is that right?

The Witness: correct.

By Mr. Mello:

Q right you are aware that the receiver has—

[447] Mr. Mello: Strike that.

By Mr. Mello:

Q. The receiver, you believe, has at least closely reached 90 percent filled registered nursing rates at approximately 22 institutions, correct? Somewhere in that neighborhood?

A. I'm not sure, but if it's in the report I certainly believe it.

Q. Let me ask it this way: are you aware that the receiver has hired more than 1400 doctors and nurses since July, 2007?

A. I believe I saw that in some document that they produced.

Q. And you agreed that that was true in your deposition in Chicago, correct?

A. Yes.

Q. And there's a nationwide shortage of registered nurses, correct?

A. Yes.

Q. And it's severe, correct?

A. I'm sorry?

Q. It's a severe shortage of registered nurses, correct?

A. Yes.

Q. Therefore, the hiring of that many registered nurses and doctors since July, 2007 is quite impressive, isn't it?

A. Yes, it is.

Q. In your opinion, the hiring of more than 1400 doctors and nurses since July, 2007 will improve the delivery of medical [448] care to California's inmate patients, correct?

A. It will, with the caveat that was introduced, I believe, in the death summary that there's concern about the potential for people not to be retained if the environment and infrastructure are not dealt with expeditiously.

Q. And you spoke about that very issue in one or both of your reports, correct?

A. That's correct.

Q. And we will get to that portion of your report later—

A. Okay.

Q. —in cross, okay?

A. Okay.

Q. I promise.

You have spoken with the chief medical officer, doctor—at Folsom Prison—Dr. Kagan as recently as August, 2008, correct?

A. I saw her in October at the national commission conference. We talked then.

Q. And you also spoke to her in August, correct?

A. I think so.

Q. Okay. And you, as i, respect her as a physician and person right?

A. Yes.

Q. You believe her to be a competent, qualified physician, correct?

* * * *

[450] Q. You're aware that the receiver—and I believe you testified to it on direct—has implemented a formal death review process.

A. Yes.

Q. And in your opinion a legitimate death review process will improve the quality of care that CDCR delivers to inmate patients, correct?

A. As long as it's used in that way. And it appears from the death summary that that's what they intend to do.

Q. An effective and utilized death review process improves quality of care, correct?

A. Yes, it can.

Q. And it's your testimony that you've reviewed the receiver's most recent analysis of 2007 deaths, correct?

A. Correct.

Q. And you also testified earlier in your deposition that you reviewed the 2006—the analysis of 2006 death reviews, correct?

A. Yes.

Q. And in that report, the 2006 report, which is Defendants' exhibit 1107, the receiver reported that there were six asthma deaths that are were preventable in 2006, correct?

A. Correct.

Q. Do you understand in reviewing the 2007 death review report that there were zero preventable deaths due to asthma-related [451] issues in 2007?

A. Correct.

Q. You've spoken about "possibly preventable" and "preventable," and those are defined in the 2007 death report, correct?

A. Correct.

Q. The 2007 death report defines "possibly preventable" as a death that in the judgment of the reviewer better medical management or a better system of care May have prevented the patient's death, correct?

A. Right.

Q. It uses the word "May have." does that mean it's more or less likely than not that better care would have prevented the death, or can you tell?

A. I have not talked with any of the people who participated in the death review process, so I really can't answer that.

Q. It uses the term "preventable," and it defines "preventable" in that report, as well. It defines a preventable death or the definition of "preventable" is:

> "in the judgment of the reviewer better medical management or a better system of care would likely have prevented the patient's death," correct?

A. Yes, that's correct.

Q. So that means it's more likely than not that better care would have prevented the patient's death, correct?

[452] A. Correct.

Q. And that's versus May have prevented the patient's death, which is defined as "possibly preventable," correct?

A. Correct.

Q. So you don't know whether or not of those possibly preventable deaths identified in the receiver's report that any of them would have occurred, correct? Would not have occurred with better care, correct?

A. Can you redo that question?

Q. Sure. You believe that—you understand that the term "preventable" and "possibly preventable' are being used differently in the report, correct?

A. Yes.

Q. And "preventable" uses the term "would likely," correct?

A. Yes.

Q. Does that mean to you or do you understand that to mean that the death would have more likely than not occurred with better care and, therefore, it's deemed preventable?

A. The death more likely would not have occurred.

Q. With better care.

A. Correct.

Q. And that would be a preventable death?

A. Correct.

Q. Can you say the same thing with respect to the definition of "possibly preventable"?

[453] A. No, I think the conclusion suggests less clarity with regard to the predictability of the death.

Q. In fact, it suggests that it's less likely than not that the death could have been prevented, correct?

A. So—

Ms. Hardy: Objection, Your Honor.

The Witness: —I'm a little confused by the question, again.

Ms. Hardy: Objection, Your Honor. Dr. Shansky has stated that he has not spoken to the people who have written this report about their criteria, and he's answered that question.

Mr. Mello: I have two responses to that, if I May. Judge Henderson: well, let me just—answer the question as it's posed to you.

The Witness: can you read it back to me?

By Mr. Mello:

Q. Sure.

The "possibly preventable" definition says that better care May have prevented the patient's death, correct?

A. Correct.

Q. And "May have" suggests that it's not more likely than not that better care would have prevented the death, but less likely than not that better care would have prevented the death, correct?

[454] Judge Karlton: Are you asking this as a question of English or a question of—

Mr. Mello: I'm asking him his understanding based upon his experience whose done—and he's got an understanding of the term "possibly preventable."

The Witness: I don't think I would say "less likely." I would interpret it as fifty-fifty.

By Mr. Mello:

Q. Okay. But, again, you haven't had the opportunity to speak to the receiver?

A. Correct.

Q. Or Dr. Imai who authored the report, correct?

A. Correct.

Q. And he will not be testifying at this trial, correct?

A. I don't know.

Q. You are aware that in the receiver's ninth quarterly report, the receiver stated that:

> "prisoner—the prisoner death rate in California's prisons has trended downward in the last 10 quarters starting in January 1, 2006," correct?

A. That's in the death review summary, the more recent death review summary. Is that what you're—

Q. I believe it's in the ninth quarterly report, as well.

A. Okay.

Q. Do you believe that to be true?

[455] A. I'm sorry?

Q. Do you believe that the death rate has trended down in the last 10 quarters starting in January 1, 2006?

A. Yes.

Q. Okay. And you agree with the receiver that the downward trend in mortality rates is related, in part, to an influx of new physicians and nurses, correct?

A. Correct.

Q. And in your opinion, the downward trend is very encouraging with respect to whether and when constitutionally-adequate medical care can be provided system-wide, correct?

A. Correct.

Q. In your opinion, while not the only factor, mortality rate is an important factor related to a constitutional system of prison medical care, correct?

A. It's a significant factor, yes.

Q. And are you aware that in a report done by the Department of Justice that California ranked in the top 15 with respect to death rates nationwide systemwide?

A. Yes, I've heard that.

Q. And are you aware that Pennsylvania ranked in the bottom five?

A. I don't recall looking at Pennsylvania, but I did see the document. It's—the one I saw was several years old.

Q. It was from analysis from even before the receiver, correct?

[456] A. Correct.

Q. And it showed that California was well below national averages, correct?

A. Yes.

Q. And it showed that California was well below regional averages, correct?

A. I believe so, yes.

Q. And that was, again, prior to the appointment of the *Plata* receiver?

A. Yes.

Q. In your opinion—and I believe you testified to this—it is possible that some units in California's prisons are currently providing constitutional levels of care to inmate patients, correct?

A. That's possible.

Q. In your November 7—November, 2007 report, at pages four and five, paragraph 12—and I don't quote it, so I summarize it. But we will pull it up for you.

You note that the reception center screening at CIM is too small, and each room is separated only by a thin white fabric folding screen.

Do you remember that?

A. Yes.

Q. Take your time getting there. Do you remember that?

A. Yes, I do.

[457] Q. Okay. In your opinion, that particular space issue could be addressed by providing a more appropriately-designed screening area, correct?

A. Yes.

Q. And it wouldn't necessarily require the reduction in the prison population, correct?

A. With regard to the use of that space and having two people simultaneously?

Q. Yes.

A. Yes, you could address that by changing the spatial arrangements.

Q. Without the release of prisoners, correct?

A. Yes, that's correct.

Q. On page five of your report in November—paragraph 13—in November, 2007, you state that Kern Valley State Prison is emblematic of inadequate clinical space.

Do you remember saying that?

A. What paragraph?

Q. Paragraph 13. I believe it's page five.

It's also on the screen, doctor.

A. Yes, I see it.

Q. In your opinion, new construction or module spaces could assist in alleviating that problem, correct?

A. Yes, the space issue could be addressed by new spatial configurations.

[458] Q. In fact, alternatives for creating additional healthcare space could include the rental of trailers, use of modulars, or prefabricated buildings, or simply fixing current space, correct?

A. I don't know about fixing the current space, but the other options are certainly possibilities.

Q. Okay.

In your opinion, the management and maintenance of medical records has been a problem at CDCR, correct?

A. Yes.

Q. And it's your understanding that many prisons' medical departments now operate at least two shifts, correct?

A. Yes.

Q. Okay. And that's a major improvement in your opinion, correct?

A. Yes, that would allow them to utilize more staff in order to get the job done.

Q. And in your opinion, medical records can be improved with more shifts, correct?

A. Yes.

Q. And in your opinion medical records could be improved with more medical record staff, correct?

A. Correct.

Q. You visited Pleasant Valley State Prison in August of 2007, correct?

[459] Pardon me, 2008.

A. 2008, I believe, right.

Q. Tried to trick you. No, I'm sorry.

So you visited that prison in August of 2008, and you noted that several inmates failed to receive follow-up with a primary care physician, correct?

A. That's correct.

Q. In your opinion, one potential fix for that problem would be increasing staffing, correct?

A. Well, staffing alone is not going to fix that. You have to put in the systems to ensure that the scheduling takes place; that their documents from the offsite encounters are available and reviewed so it's a multifactorial problem that has to be addressed in order to fix it.

Q. But one component of that multifactorial problem is physician staffing, correct?

A. Yes.

Q. And in your opinion, those other factors that you mention would contribute to the fix of that particular problem, correct?

A. Yes.

Q. As would additional clinical space at pleasant valley state prison?

A. Yes.

Q. In your opinion, you expect that the receiver will use additional hirings, temporary space, permanent space, electronic [460] medical records and increased staff to deal with paper records to address increased population, correct?

A. Yes, the receiver can use all of those tools.

Q. In your opinion, the adjustment of the medical classification system is also a possible solution to the staffing issues at some of the remote prisons, correct?

A. Yes, if you're talking about, in essence, kind of triaging patients with more clinical issues to facilities that have more intense medical resources.

Q. And another potential fix or partial fix to problems at remote prisons would be increased use of telemedicine, correct?

A. Yes.

Q. You are aware that in the findings of fact and conclusions of law appointing the receiver in this case the *Plata* court stated that, quote:

> "the provision of adequate medical care in this situation presents a classic example of a polycentric problem," end quote.

You're aware of that, right?

A. I believe so. That was awhile ago.

Q. And do you agree that it's a polycentric problem?

A. I think it was at that time, yes.

Q. You believe it is today?

A. Well, at this point in time, I think conditions have changed. They have changed with the advent of the receiver. And [461] the changes—and, again, this comes partly from my experience—the receiver—the receiver has a set of tools to, in essence, create a new system.

The receiver does not have a tool that directly addresses crowding. Instead, what the receiver is left to do is do—use a bunch of tools in a variety of ways because of the stresses put on the system by overcrowding. And as a result, the longevity of the receivership will unquestionably—I can say this with a hundred percent certainty—the longevity of the receivership will be extended if crowding isn't addressed and addressed directly and significantly.

And the end result is that the receiver's ability to fix things will be substantially delayed and, therefore, what will occur as a consequence is unnecessary, avoidable suffering, hospitalizations and potentially deaths. And that's the impact of crowding on the receiver's ability to solve things using his tools.

Q. So, in summary, it will take the receiver longer if crowding isn't addressed, in your opinion?

A. Substantially longer.

Q. In fact, I believe at the time of your deposition you couldn't tell us how much shorter it would be with population reduction measures, correct?

A. It depends on the degree of population reduction. But I could—I was thinking about this prior to my testimony. And [462] given the receiver's abilities to use those tools as demonstrated thus far, if the population were reduced to—I don't know—let's say a hundred thousand total—and I've been thinking about this—I believe that the majority of prisons would be constitutional within three years.

Q. So even with a reduction in population of 56,000 inmates it would take three years, in your opinion, to have 17 of the institutions in constitutional compliance?

A. Well, it's possible the receiver could, in some instances, go more rapidly in achieving those goals. But given my understanding of the plans with regards to I.T. and some of the other issues, I think that's completely reasonable.

And maybe it would be two-thirds or three-quarters would be constitutional within three years.

There's no question that with regard to hiring, for instance, there's been a significant improvement.

Q. And those items in his toolbox that are separate and apart from overcrowding, those are some of the interrelated components to the delivery of a constitutional — the delivery of constitutionally-adequate medical care?

A. Yes.

Q. And was the system overcrowded in 2005?

A. Was the system overcrowded? I don't have the numbers.

Q. Do you know if it was overcrowded when your deposition was taken in December of 2007?

[463] A. Yes.

Q. Was it overcrowded when I took your deposition in December of 2007, and you told me that the delivery of medical care in California's prisons was a polycentric problem?

A. That's in which deposition?

Q. In your December deposition. Do you remember —

A. December '07?

Q. Correct.

A. Okay. Let help just quickly.

Q. And why don't we just pull it up? Page 88, lines 20 through 24.

A. This was at the time of the—this is prior to the receiver.

Q. Okay.

A. Yes.

Q. So you agree?

A. Yes.

Q. Okay.

A. At that time.

Judge Reinhardt: Can I ask you a question on that?

The Witness: Yes.

Judge Reinhardt: What does the term "polycentric problem" mean?

The Witness: Well, from the way I interpret it, it connotes a problem that has multiple sources that are [464] simultaneously impacting it.

Judge Reinhardt: Is it possible to have a polycentric problem with a primary cause?

The Witness: I think so. I think so.

By Mr. Mello:

Q. Just to follow up on that point, the delivery of medical care in California's prisons involves multiple interrelated components, correct?

A. Correct.

Q. And you've discussed some of those interrelated components already. You've discussed adequate number of adequately trained and credentialed physicians, correct?

A. Correct.

Q. Appropriate number of assistants and staff and nurses and records folks, correct?

A. Correct.

Q. An adequate environment within which to work, correct?

A. Correct.

Q. And a system for documenting healthcare interactions, correct?

A. Correct.

Q. Just to name a few?

A. Yes.

Q. These components of a constitutionally-adequate medical care system also include and must include a system to track and [465] ensure continuity with regard to all elements of professionally-created plans, correct?

A. Correct.

Q. A system that allows for the movement of patients to improve—to appropriate levels of care based upon need and complexity of medical problems, correct?

A. Correct.

Q. The ability to ensure timely access to specialty care?

A. Yes.

Q. The ability to ensure access to medical care regardless of custody level?

A. Yes.

Q. Sufficient community resources to provide offsite services?

A. Yes.

Q. And in your opinion it's difficult to rank those interrelated components in terms of importance because they are interrelated, correct?

A. Correct.

Q. In fact, with respect to those components, you are reluctant to rank one of them first, correct?

A. Correct.

Q. In your opinion, one of the most important things in terms of remedying CDCR's failed or formerly failed medical care delivery system is the culture, correct?

A. The culture is important.

[466] Q. And culture helps ensure timely and appropriate access to medical care, correct?

A. Culture is crucial, in my view, because appropriate culture connotes a healthcare staff team that is invested in their patient outcomes.

That's the critical aspect of culture.

Q. How many institutions have you visited in the last year-and-a-half?

A. Nine.

Q. Nine.

And did you see that culture that you just described when you met with medical and custody staff at those institutions?

A. I would—it would be presumptuous of me with my quick one day in-and-out describe the culture. I was impressed at a variety of places with the individuals that I did get a chance to speak with, in that there did seem to be an increased level of concern about patient outcomes.

Q. And didn't many of those individuals report you to that the culture that you described earlier had improved at their institutions?

A. We didn't really discuss the culture much. For instance, when I was working with—when I was reviewing medical records, one of the things I always do is have a staff clinician review the records with me so that I am not concluding that something [467] wasn't there or didn't happen on the basis of my own observations, but rather it's a shared conclusion, shared which a person who works in the institution and knows where to look in the extra places, *et cetera, et cetera*.

When we were doing that and we would find things that should have occurred, but didn't occur, or things that didn't occur timely, my sense was that the individuals I talked to generally were extremely concerned about it and extremely bothered by the fact that there was this risk to their patients.

Q. So they care about their patients?

A. Yes.

Q. And they wanted the best for their inmate-patients?

A. Yes.

Q. There's a direct correlation between the quality and stability of leadership and the quality of care, isn't there?

A. Yes, there is.

Q. Okay.

In your opinion, a factor that could result in the insufficient delivery of specialty care to CDCR inmates is inadequate clinical patient communication with regard to current and future plans, correct?

A. Yes.

Q. In your opinion, simply reducing the number of the prison population by itself will not cure the deficiencies with respect to specialty medical care at CDCR, will it?

[468] A. Well, if—let me respond in the way I understand it. If some of the absence of follow-up visits and communication between patient and clinician after an offsite service was provided for a serious medical problem, if the reasons for the visits not occurring were because of a demand to resource mismatch, then crowding and reducing the population will bring the demand-to-resource relationship more into line and the probability of those visits and the communication occurring will be greatly enhanced.

Q. Do you know specifically whether any of those circumstances that you just described, or possibilities, were the result of overcrowding?

A. I know that clinicians told me that patients were not seen and followed up timely because of lack of available space, slots for physicians to see them timely. And that was partly related to custody issues, partly related to the physical space issues, only one exam room in a clinic area. But it was their perception that crowding was the major factor that impacted it.

Q. And, again, those issues could be addressed by increasing space and increasing staffing, correct?

A. Potentially.

Q. In your opinion, an effective computer network is essential to providing medical care access to clinical information, correct?

A. Yes, in this day and age it really is critical.

* * * *

[477] newly-hired clinicians at CDCR, had you?

A. No, not at that time.

Q. And when you wrote that you were not aware of any surveys done by CDCR or the receiver regarding newly-hired clinicians, were you?

A. Not at that time.

Q. And that opinion was not based—pardon me.

And that opinion was not based of any studies of newly-hired clinicians in any other systems, was it?

A. No.

Q. And that opinion was based solely on antidotal information you received from individual physicians in other states who quit their jobs, correct?

A. Well, based on my experience, not just antidotal information.

I have dealt with that myself in hiring people.

Q. But it was not based up any studies or surveys or reports in California, correct?

A. Correct.

Q. Dr. Shansky, you have experience working with or evaluating badly overcrowded systems, including Illinois in the '80's, correct?

A. Correct.

Q. In fact, as you testified on the direct, you were the medical director of Illinois system for a period of years.

[478] A. Yes.

Q. And Illinois system eventually—or was in constitutional compliance, correct?

A. Illinois system was what?

Q. Let me back up.

A. Okay.

Q. At the time it was overcrowded, was the Illinois system in constitutional compliance?

A. I was fortunate. At the time that I became medical director, the system was not badly overcrowded. There were two existing lawsuits. One was *Lightfoot versus Walker*, involving *Menard*, the other was *Cook versus Roe*, involving *Stateville*.

But those cases were not about crowding. It was about—they were about an inadequate healthcare system. And those were resolved within a year or two, after I came onboard. But we didn't have a crowding case.

Q. You did not have a crowding case, but I believe you testified that you had crowding?

A. Later on in my tenure, yes.

Q. And were you able to address the medical deficiencies in your systems without a prisoner release order in Illinois?

A. Yes.

Judge Henderson: Can you clarify whether "crowding" is the same as "overcrowding"?

Mr. Mello: sure.

[479] By Mr. Mello:

Q. You had overcrowding in Illinois, correct?

A. Nowhere near to the extent that it is here. I think some places May have gotten as high as about 140 percent of occupancy.

Q. And when you say "140 percent of occupancy," is that operable capacity, design capacity, some other capacity?

A. I think it's design capacity.

Q. Have you heard the term "operable capacity"?

A. I'm not sure what that means, though.

Q. And but Illinois was overcrowded, correct?

A. Yes.

Q. And it solved its medical care deficiencies while overcrowded without the use of a prisoner release order, correct?

A. Correct.

Q. Dr. Shansky, you worked as a consultant for CDCR in a series of two-year contracts through June of 2006, correct?

Let me just back it up, and make it less complicated. You worked as a consultant to the CDCR for some period of time, correct?

A. Yes.

Q. And you worked on this very *Plata* case for CDCR, correct?

A. Yes.

Q. And you stopped working for CDCR on *Plata* in June of 2006,

* * * *

[483] something that could be addressed effectively relatively quickly.

Q. And I believe you've testified generally about population reduction numbers to 100,000. That's a number you used?

A. I gave that as a hypothetical.

Q. As a hypothetical example.

Isn't it true, in fact, that you hesitate today to come up with a figure to which the prison population needs to be reduced to achieve constitutional levels of care, because in your opinion that would require doing a study that requires data from the *Plata* receiver?

A. Yes, that's correct.

Q. And in your opinion, if the only improvement that was made in the next two years is the decrease of the population in California's prisons by 40,000 inmates, and everything else remained the status quo, CDCR would still not have a system-wide constitutionally-adequate medical care system, correct?

A. Yes, I believe that.

Q. And you, Dr. Shansky, do not have an opinion as to whether or not population is the primary cause of the unconstitutional delivery at each of the institutions covered by the *Plata* stipulation, do you?

A. I have. My opinion is that the primary cause of the system's unconstitutionality, ongoing unconstitutionality is overcrowding.

[484] Mr. Mello: I think I only have one more question. I'd like to pull up page 151 of his first deposition, lines five through 10.

The Witness: 151?

By Mr. Mello:

Q. It's also on the screen, Dr. Shansky.

A. Yes, I'm looking at it in the document.

Q. And Dr. Shansky, I'm just going to read that into the record.

The question was:

> "Dr. Shansky, do you have an opinion as to whether or not population is the primary cause of the unconstitutional delivery of healthcare in each one of the 32 institutions?
>
> "Answer: I don't have an opinion on that because I have no data."
>
> Do you see that?

A. Yes. The critical phrase there is:

> "in each one of the institutions."
>
> I couldn't speak to each one of the institutions.

Q. So your testimony is that you can't tell this court whether or not overcrowding is the primary cause of the unconstitutional delivery of healthcare at the 32 prisons that were still subject to the *Plata* stipulation in December, 2007?

Judge Karlton: That's different question. Different [485] question.

This question says:

"in the 32."

The other question says:

"in each of the 32."

By Mr. Mello:

Q. Okay. Can you tell me whether it's the primary cause at each institution in the system?

You said before you couldn't. Can you tell me today?

A. At each individual prison, I can't comment on each individual prison. I can tell you for the entire system there's no question in my mind that it's the primary cause of ongoing unconstitutionality, and it's overcrowding.

Q. Despite the fact that you can't tell me whether it's the primary cause at any of the prisons that you didn't visit?

Ms. Hardy: Objection, argumentative.

Objection, argumentative.

Judge Henderson: Answer it, Dr. Shansky.

The Witness: Could you repeat the question?

Judge Henderson: In spite of the fact that you said here that you don't have an opinion on whether it's unconstitutional in each one of the 32 institutions.

By Mr. Mello:

Q. So the question is: Can you tell me—it's a new question. Can you tell me which one of the 33 California [486] institutions at which overcrowding is the primary cause of the unconstitutional delivery of healthcare in light of your previous testimony?

A. At which of the 32 do I believe based on my experiences that it is the primary cause. I can tell you from, A: my review of nine facilities, it's clearly the primary cause at those nine.

And in reading the receiver's documents about the system, in general, including the death review summary, the conclusion is, to me, not even in doubt that for the entire system this is the primary cause of ongoing unconstitutionality. And this is the major reason that the receiver will take longer to fix the system than were the population reduced.

Q. And back to that death review, you've reviewed the 2007 death review, correct?

A. Yes.

Q. And that death review provides there were three preventable deaths in 2007, correct?

A. Yes.

Q. Three out of 395 that were reviewed, correct?

A. Yes.

Q. That's well below 1 percent, correct?

A. Yes.

Q. Is that number surprising to you?

A. No, that number is not surprising. But when you add the preventable with the possibly are preventable that number is [487] surprising.

Q. And it's your testimony that "possibly preventable" means it's fifty-fifty that better care would have possibly prevented the death?

A. Mitigated the outcome, yes.

Q. One second.

Mr. Mello: That's it. Thank you, Dr. Shansky.

The Witness: Thank you.

Judge Henderson: We're going to take a 15-minute recess at this point.

The Clerk: Court's adjourned.

(Thereupon, a recess was taken.)

Judge Henderson: Okay. Your cross-examination.

Cross-examination by Mr. Kaufhold

Mr. Kaufhold: Thank you, Your Honor. Steve Kaufhold for the Legislative Intervenors.

By Mr. Kaufhold

Q. Good morning, Dr. Shansky.

A. Good morning.

Q. Turn to the first page of your second expert report from September of this year. On the first page, there's a heading that sets forth the basis for your expert opinions.

In paragraph five there you write:

> "I have been asked to render my opinion with respect to whether overcrowding in the [488] California Department of Corrections and Rehabili-

tation CDCR is the primary cause of the current unconstitutional conditions experienced by members of the *Coleman* and *Plata* classes." do you see where I'm referring to?

A. Yes.

Q. My question is this: When you refer to the current unconstitutional conditions, was that something that was part of your research and analysis and opinion, or is that a fact that you took as a given in your analysis?

Ms. Hardy: Objection, Your Honor. Relevance.

Judge Karlton: Overruled. Oh, excuse me.

Judge Henderson: It's been said better than I could.

The Witness: I took it as a given, but it also was confirmed by my reviews of the prisons I went to.

By Mr. Kaufhold

Q. So is it your testimony that you have an expert opinion on the legal issue of the current constitutionality of the California prisons?

A. Ask the question again.

Q. Sure. My question is: is it your testimony that you have formed and have today an expert opinion regarding the current constitutionality of the California prisons?

A. No. As I said, that was a given, but my reviews were consistent with that given.

[489] Q. just to make completely clear. So that is not part of the formal opinion that you are offering to the court today; is that correct?

A. "That" being?

Q. "That" being the ultimate expert opinion that there is current unconstitutionality in the California prisons. That is not part of your expert opinion; is that correct?

A. That's correct.

Q. Turning to the final page of the same report, that's page 36 of your September 9, second supplemental declaration, or expert report, I'm sorry. You state:

> "based on all that I have set forth above in my previous reports, I continue to believe that overcrowding is the primary cause of the current state of medical crisis in the CDCR."

Do you see where I'm referring to?

A. Yes.

Q. And in the conclusions portions of your opinion, there's no reference to current unconstitutional conditions; is that correct?

A. In this paragraph?

Q. Correct.

A. I don't refer to that, correct.

Q. Referring to your earlier testimony when you had your conversation with Mr. Mello, you discussed the hypothetical [490] figure of a hundred thousand inmates in the system; do you recall that?

A. Yes.

Q. And you have not, however, done any systematic analysis of what an appropriate number of inmates for the California CDCR would be, have you?

A. No, because I didn't say that was the appropriate number. My testimony was if such a number were reached, hypothetically, then the receiver would be able to achieve a constitutional level of care in a majority of the prisons within three years.

Q. Right. And, in fact, in your sworn testimony to Mr. Mello, you stated you had, quote, "no clue," end quote, what an appropriate target number is; is that correct?

A. That's correct.

Q. Now, on September 28th of this year, 2008, you filed a third supplemental expert report; do you remember that?

A. Yes.

Q. Whose idea was it that you file a third supplemental report; was that your idea or Plaintiffs' counsel?

A. I discussed it with Plaintiffs' counsel.

Q. Whose idea—who was it that raised that possibility; was it you or Plaintiffs' counsel?

A. Plaintiffs' counsel.

Q. What was the purpose for that?

A. I think it was responding to the receiver's report.

[491] Q. Turning to the second page of that report, of your second report, which was submitted to the court and dated

September 28th, 2008, you state:

> "discussing this development the receiver emphasizes that, quote, 'a constitutionally adequate

> and sustainable prison medical system will not be established until the turnaround plan of action is fully implemented,'" end quote.

And then you write:

> "I agree. And the inadequate system will continue to exist for longer than otherwise—longer than it otherwise would unless there's a significant reduction in the population."

Do you see where I'm referring to?

A. Yes.

Q. And do you agree with that statement today?

A. Yes, yes.

Q. Do you believe the full implementation of the turnaround plan will ensure a constitutional level of healthcare and mental health care in California?

A. Along with the other additional changes they're making.

Q. So you believe additional changes are needed beyond those set forth in the turnaround plan?

A. No. The turnaround plan lists a variety of things, both [492] environmental and staffing and I.T. all of those things together will eventually be able to address most of the problems, unless, of course, the population wildly increases again.

Q. Right. And it is not part of the turnaround plan—there's no request or plan for a prisoner release order of any sort; is there?

A. Not that I'm aware of.

Judge Karlton: Sir, the plan requires the legislature to provide large sums of money that they have not yet done and May not do. Is your question—it appears to me, but I may be wrong—that your question is talking about a hypothetical that as of now is not likely to occur.

Mr. Kaufhold: I can't respond to the likelihood, Your Honor, but it's absolutely a hypothetical in the sense my question to the witness was that, if you assume that everything in the turnaround plan is fully implemented, fully funded, fully implemented, then would that be the result.

Judge Karlton: Okay.

By Mr. Kaufhold

Q. Now, in terms of the timeframe of possibly achieving that, Dr. Shansky, I think you've testified previously that it wasn't foreseeable when that could be achieved absent a prisoner release order or a population cap of some sort; is that correct?

A. That's correct.

* * * *

[497] A Yes, I did see patients housed in those arrangements with complex medical problems.

Judge Karlton: did you actually visit mule state? The Witness: no, not on this tour.

By Ms. Hardy

Q. Dr. Shansky, Mr. Mello asked questions about the items that you referred to as items in the receiver's toolbox that include staffing, the pharmacy system. Will those improvements accomplish and create—use of those tools create a constitutional medical system if the receiver uses them?

A. You have to—you are talking about an entire system of the Department of Corrections, and you would have to be able to integrate the implementation of all those changes, and currently you would be forced to do that in the face of dramatic overcrowding, which compromises your ability to successfully implement them. Whereas, in the face of a system that is not heavily overcrowded, your ability to use those tools and successfully create an adequate delivery system is greatly enhanced, and the timeframe to doing it is dramatically shortened.

Q. Mr. Mello pointed out that at certain prisons, and you agree, that if they raise the staffing levels, then that would improve care. Would that resolve the constitutional problems, by raising staffing levels?

A. No. You have to address all of these things systemwide and [498] within given facilities in order to achieve constitutional levels.

Q. In fact, the receiver has said that the system has only half the necessary space for the needed clinicians for the current population; is that right?

A. That's correct.

Q. Mr. Mello asked you whether, if prisoners are housed in non-traditional beds, they necessarily receive unconstitutional medical care.

A. Yes, he asked me that.

Q. Increasing staffing levels and clinic space will not cure the problem of non-traditional beds if those non-traditional beds are breeding grounds for disease; is that right?

Mr. Mello: Objection, Your Honor. Paul Mello again. That's an incomplete hypothetical.

Judge Henderson: Rephrase it, counsel.

By Ms. Hardy

Q. You testified that non-traditional beds in and of themselves do not mean that prisoners are receiving unconstitutional medical care, correct?

A. Correct.

Q. However, non-traditional beds do pose problems for the medical care delivery system, don't they?

A. There's ample data that shows that kind of congregated housing increases problems in a variety of ways, including the [499] risk of communicable disease, especially infections, skin infections certainly, as well as increases stress among the population that can result in various kinds of acting out, violence, et cetera.

Q. When there is acting out, how does that impact the delivery of care?

A. Then you get injuries, and it just increases the demand on a system that is already inadequate to meet the existing demand.

Q. You testified that when you do file reviews of medical files at prisons, you sit with the—with a physician from that institution as you go through the files; is that correct?

A. That's correct.

Q. And when you did the latest round of file reviews, I believe it was in August, generally you had the chief physician with you; isn't that right?

A. That's correct.

Q. And you testified that you found when you went through these files, that the physicians you talked to were concerned about their patient care and the apparent lapses; is that correct?

A. That's correct.

Q. Were the physicians surprised at the lapses?

A. No. That was, unfortunately, the pattern throughout. They were aware that the system that they were responsible for was still not adequately responding to the clinical needs.

Q. Doctor, you have been to a number of—many states, and you [500] have reviewed scores of prisons, and you have been through many prison systems. In order to determine whether or not overcrowding is the cause of unconstitutional medical care in a system, do you have to go to every prison facility?

A. No, generally not. We can go to a subset, but in this particular situation, we have evidence beyond just the personal tours. And particularly from the receiver's office there are remarkably well-documented reports that describe the ongoing deficiencies, and the resource-to-demand mismatch that is endemic throughout the system.

Q. Mr. Mello asked you about filled clinical positions, and you agreed that the receiver has achieved 90 percent of—90 percent fill rate for certain clinical positions, correct?

A. Yes.

Q. Do you know whether those are all the positions that the receiver needs in the system?

A. I do not know.

Q. And have you seen a staffing study or workload study done by the receiver to determine whether or not those positions will be sufficient for the system?

A. I don't recall seeing such a study.

Q. Do you recall talking to physicians on your tours who indicated that they had opinions about the level of staffing?

A. Yes. Some of the CMO's indicated that their view was that even if all the budgeted positions were filled, they would still [501] not have adequate clinical resources to meet the clinical demands.

Q. And then the obverse was you spoke to other clinicians who told you that, even if all the positions were filled, would they have had a place to put them?

A. I was also told by some of the CMO's that they wouldn't have space if all the budgeted positions were filled.

Q. You listed a number of interrelated factors that make up a medical care system, and that includes medical staff, medications delivery system, tracking, access to specialty care, offsite care, and you said that all of those elements are important; isn't that correct?

A. Yes.

Q. And there are deficiencies in these areas in CDCR; is that correct?

A. Yes.

Q. And what is the relationship of overcrowding to those deficiencies?

A. Well, overcrowding exacerbates demand, and when a system is not designed to meet basic needs and then you increase the demand on it, the inadequacies come to the fore much more frequently.

Ms. Hardy: Thank you, Dr. Shansky.

Judge Henderson: Thank you, counsel.

Mr. Mello: I have nothing further.

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UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

NO. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
vs.
ARNOLD SCHWARZENEGGER, *et al.*
Defendants.

TRANSCRIPT OF PROCEEDINGS

San Francisco, California
Friday, November 21, 2008

* * * *

[724] still some clarification which may avoid the need for a witness.

Judge Karlton: Why don't we take our break?

Mr. Bien: If you could indulge us to have that witness later in the trial if we can't work it out.

Judge Henderson: Okay. That's fine.

Mr. Bien: Thank you.

Judge Henderson: Then we are going to get to defendants' case, but let's take a recess, 15 minutes for that transition.

Judge Karlton: There was something the Plaintiffs wanted to put on.

Judge Henderson: Plaintiffs have rested, right?

Mr. Bien: Your Honor, I think as long as if there's any problem on the foundation for these charts, we can do it later in the trial?

Judge Karlton: Okay.

Judge Henderson: Okay.

Okay. Let's proceed. The preliminary statement that the Court remains of the opinion that the witnesses listed for today are more properly phase two, but we're not going to tell you you cannot put them on today.

Mr. Lewis: Good morning, Your Honors. Kyle Lewis for the defense. The state defendants now call Todd Jerue.

TODD JERUE

[725] Having been called as a witness by the defendants was first duly sworn and examined as follows.

The Witness: Yes.

The Clerk: State and spell your full name for the Record.

The Witness: My name is Todd Jerue. Spelling is T-O-D-D-J-E-R-U-E.

Mr. Lewis: Your Honors, Defendants have submitted a trial affidavit for Mr. Jerue. Specifically, it's identified as exhibit 1008. We ask the Court to take it under submission at this time.

Judge Henderson: We will do that.

Direct Examination by Mr. Lewis

By Mr. Lewis

Q. Good morning, Mr. Jerue.

A. Good morning.

Q. What is your current job title?

A. Program budget manager for the Department of Finance for the State of California.

Q. How long have you worked for the State of California?

A. Twelve years in February.

Q. Could you please provide the Court with a brief description of your employment with California?

A. Sure. I began in February of 1997 as an analyst for the Department of Finance. I worked in that capacity for about [726] 3-1/2 years on various budgeting assignments. In the summer of 2000, I was promoted to supervisor, which is called a principal program budget analyst. That was on a general government assignment.

About eight months later I rotated to a new assignment, which was department of justice judiciary assignment. In 2002 I rotated to the Department of Corrections assignment. In October of 2004 I was promoted to Assistant Program Budget Manager over half of our unit that handles public safety programs, corrections, judiciary department of justice. In June of 2006, promoted to my current position.

Q. And as program budget manager for the Department of Finance, what are your responsibilities?

A. I manage a unit of 22 people. Our responsibility is that we review and oversee the support and operating budgets for about 50 state departments.

Q. And when you say the preparation and submission of the support budgets, what exactly does that mean?

A. Well, the main function of that is starting with the current budget act as a starting point, the main role we do is that we review and analyze budget change proposals submitted by those departments.

Q. And you mention that you oversee the preparation of those budgets for about 50 state agencies and departments. Is one of them the California Department of Corrections and [727] Rehabilitations?

A. Yes, it is.

Judge Karlton: Before you go on, I'm confused. The budget, do you, for example, do the budget, or do you review the budget that comes up from the agency?

The Witness: we review the agency's proposals for new spending, and then we physically public a book—

or now on the internet—that actually has all of those departments in one place.

Judge Karlton: I'm afraid I haven't asked the question appropriately.

Do you put the budget together for an agency, or do they send you a proposed budget?

The Witness: They send us a proposal budget.

Judge Karlton: Okay.

Judge Reinhardt: Do you then change it? You review it? You cut it? You give them more money than they ask for?

The Witness: We have given them more than they've asked for before, but, for the most part, we budget on the margin. So we have a base budget. Most of our changes are when they request new money, but in order to balance the budget, there are times we have to make budget reductions, also.

Judge Karlton: My fault, not yours. The end of the year or whenever the legislature gets around to it, you get,

* * * *

[734] And mental. It did not include dental.

Judge Karlton: All right.

By Mr. Lewis

Q. Mr. Jerue, in brief, what did your analysis show regarding the amount of budget expenditures for CDCR healthcare services?

A. In general or for specific years?

Q. Just in terms of raw numbers.

A. In terms of raw numbers? Can I refer to my affidavit?

Q. Please.

A. If you go back to the other chart, I can show you on the first chart—it shows in '94/95 fiscal year the department spent $344 million for these services.

Then moving forward approximately ten years, can you tell what the number—what the amount of expenditures in 2005/2006 was?

A. Yes. It grew to 1.252 billion.

Q. What was the amount for 2006, 2007?

A. 1.365 billion.

Q. What was the amount for 2007, 2008?

A. 2.249 billion.

Q. So, over a period of years, how much has the amount of funding grown for CDCR's healthcare services?

A. From where we started '94/95 through the most recent actual data from '7/'8, it grew from 344 million to 2.249 Billion which is an increase of 554 percent.

[735] Q Thank you.

Now, did you and your staff also analyze the trend of the California state inmate population at that time between 1995 and 2006?

A. Yes, we did.

Q. And based on your analysis how much did the CDCR population grow between 1995 and 1996 (sic)?

A. The population for the years '94/'95 through '7/'8 grew approximately 30 percent. I have the actual numbers if I can refer to my affidavit.

Q. I think the Court has that. It's all right. Thank you, though.

So between 1995 and present, how much did the CDCR annual budget expenditures for healthcare grow?

A. Five hundred fifty-four percent.

Q. During that same period, how much did the population grow?

A. Approximately 30 percent.

Q. Did you and your staff also perform an analysis of the cost per inmate expended by CDCR on its healthcare needs for the population over the course of years?

A. Yes, we did.

The Clerk: Five minutes, counsel.

Mr. Lewis: Thank you.

By Mr. Lewis

Q. What did your analysis show?

[736] A Our analysis showed that in '94/95, the per-inmate cost was $2,714 growing to $13,778 in '07/'08, which is an increase of 408 percent.

Q. And so looking at the chart from the year 2006 to 2008, what was the percentage of growth in just those two years?

A. That was approximately 80 percent.

Q. And looking ahead, what is the total anticipated expenditure for CDCR healthcare services, to include mental and medical health, for fiscal year 2008/2009?

A. Currently, 2.193 billion.

Q. I notice there's a slight decrease in the FY, fiscal year, 2008/'9 versus the previous year 2007/'8. Can you explain that?

A. Yes, I can. For the prior two fiscal years, the budget act contained an unallocated pot that was then used for the receiver within any given year within that current year for remediation efforts. In the '7/'8 fiscal year, that was $125 million. That was not included in the '8/'9 budget act.

Q. Based on your analysis of the figures for budget expenditures, what have you learned about the amount of funding appropriated to CDCR between 1994 and 2008?

A. What I have learned is that the expenditures have grown over 550 percent with an accompanying increase in per inmate spending of over 400 percent, while, at the same time, the population has only grown approximately 30 percent.

* * * *

[741] hope.

Mr. Mello: We are done with this witness. I believe you were done, correct?

Judge Reinhardt: I was just trying to find out if I could take anything from the evidence that would be helpful to your case.

Mr. Lewis: I have no further questions. Thank you, Mr. Jerue.

Judge Henderson: Let me—before we have cross, does this chart show us—we know there's been a 554 percent increase over the years of this chart with an attendant 30 percent population increase. Does this show us—does it break down as to, when we reach the high point, what this money was used for?

And what I have in mind is, as recently as three years ago, perhaps, I took a tour of a prison in which the medical people didn't even have a wash bowl to wash their hands. Is this—would it be fair to conclude that some of that increase was just to get things that just had not been furnished, or do you know?

The Witness: The department would have the exact ways that the money was spent. I would have general ways that the money was spent, or have some knowledge of, for example, what the receiver has done since his inception.

Judge Henderson: But there are figures someplace to [742] tell you exactly how the two billion—

The Witness: That's correct, especially the growth in the last couple of years. There would be specific proposals that the Administration has put forward, whether it be for mental health care or from the receivership, to grow these budgets.

Judge Karlton: I take it no—I don't know whether I—I take it that there's no case on these charts, or even in your documents, whether or not the initial amount of $344 million was an appropriate sum. All this chart may prove is that there was desperate underspending until now; is that right or wrong?

The Witness: I don't think I could speculate on either side, but I can't sit here and tell you I can say either way whether $344 million was the correct number in '94/'95

Mr. Lewis: Thank you, Your Honor.

Thank you, Mr. Jerue.

Judge Henderson: Thank you, Counsel.

Cross?

Ms. Morris: Maria Morris on behalf of *Coleman* Plaintiffs.

Cross-examination by Ms. Morris

By Ms. Morris

Q. Mr. Jerue, I would like to take a moment to look at your trial affidavit, which is Document 346

* * * *

[745] Q. Okay. So when you're comparing costs from 1994/1995 to 2007/2008, you're not actually comparing necessarily the same set of costs; is that correct?

A. It's possible.

Q. You just don't know?

A. Correct.

Q. Okay. Do you know how much of the current costs of medical care in 2007/2008, how much of those were for administration costs?

A. It was factored into the number. I don't have that with me today.

Q. Do you know how much of those—of the costs currently are custody-related costs?

A. Once again I could guess at a number. I don't have the exact number with me today.

Q. Okay. So again, you don't know—that is the portion that you don't know about for 1994 and '95, whether that was included?

A. That's correct.

Judge Karlton: Can you give me a rough estimate as to those—rough, as to those components?

The Witness: As of today?

Judge Karlton: Yes.

The Witness: I would say roughly for both components it would be approximately 250 to 300 million in [746] today's dollars.

By Ms. Morris

Q. So about a fifth to a sixth of the total costs?

A. That's correct.

Q. In this chart as far as—rather, in your—in your trial affidavit, as far as I can tell, you did not factor in inflation; is that accurate?

A. That's correct.

Q. And you didn't factor in medical care inflation specifically either, did you?

A. No. We just compared the actual costs of the department.

Q. Okay. Do you know how much inflation there has been in medical care since 1994?

A. No, I don't.

Q. Have you ever used the consumer price index?

A. For some applications, yes.

Q. So you use it in your work?

A. Rarely. Rarely in what we do in budgeting, but every now and then.

Q. I ran some numbers on the consumer price index to see how much growth there has been in today's dollars, and I'd like to just put up for the Court the CPI calculator.

Mr. Lewis: Objection, Your Honor. This lacks foundation, and also the witness or the—I'm sorry—counsel is testifying now, it would seem.

* * * *

[750] from June 30th, 1995 through June 30th, 2008, that's comparing healthcare costs, is that how you understand this as well?

A. I never looked at the chart.

Q. You've never looked at the Medical Care Inflater Chart?

A. No.

Q. Okay. So you have no knowledge, when you talk about how much the cost has increased, what percentage of that is due to inflation?

A. No, because we didn't do our analysis based on that.

The Clerk: Five minutes, Counsel.

Ms. Morris: Okay.

Judge Henderson: Counsel you said western urban. This says all urban.

Ms. Morris: Let's see—can you blow up the place in the top right above the chart where it says—down lower, the—inside the chart, that portion.

Judge Henderson: There's some blurred reading. I can't see.

Ms. Morris: I do have a copy of it I can provide for the Court—and I can provide—

Judge Henderson: Just give it to the Deputy. Okay.

Judge Reinhardt: We see it. We see it.

Judge Henderson: it's just not clear on that chart.

By Ms. Morris

Q. Also, you don't give any information in your affidavit

* * * *

[752] increasing the quality of healthcare?

Mr. Lewis: Objection, Your Honor. Vague, and this witness is not being proffered for any of this evidence.

Judge Henderson: I think it's a fair cross-examination question, and I'll allow it.

The Witness: No, I wouldn't have the expertise to know how it's affecting the quality of the care.

By Ms. Morris

Q. So you did not consider inflation, you did not consider quality of healthcare, quantity of healthcare, for any of the years between 1994 and 2005, and you don't actually know what the starting point included in your categories of healthcare spending, correct?

A. That's correct.

Ms. Morris: Your Honors, we would move to strike the testimony of this witness as lacking foundation, and as being irrelevant and not probative to any matter in this case, and we would like also to strike the chart which is based entirely on his testimony.

Mr. Lewis: Your Honor, if I may address that via redirect?

Judge Henderson: You may. We'll take it under—

Redirect Examination by Mr. Lewis

By Mr. Lewis

Q. Mr. Jerue, when the chart comes up, I would like you to

* * * *

[755] regarding foundation or anything like that, I could address that. I tried to establish these are records and they are based on numbers his unit is responsible for keeping.

Judge Henderson: No further questions for anyone? I'm going to deny the motion and rule it goes the weight of this testimony and not its admissibility, counsel.

Thank you, Mr. Jerue.

You may call your next witness.

Ms. Tillman: The witness is right in the hallway, Your Honor.

Judge Henderson: Step forward, ma'am, and be sworn in.

Ms. Tillman: Your Honor, this is Ms. Cynthia Radavsky from the Department of Medical Health. My name is Lisa Tillman on behalf of the *Coleman* defendants.

CYNTHIA ANNE RADAVSKY

Having been called as a witness by the defendants was first duly sworn and examined as follows.

The Clerk: State and spell your full name for the record.

The Witness: My name is Cynthia Anne Radavsky, R-A-D-A-V, as in Victor, -S-K-Y.

Ms. Tillman: Good morning, Your Honor. Lisa Tillman on behalf of the defendants. We've presented the Court with a trial affidavit of Cynthia Radavsky. I think it was [756] tagged as Exhibit No. 1106. We respectfully request this court admit that trial affidavit into evidence today.

Judge Henderson: 1106?

Ms. Tillman: I believe it is 1106.

Judge Henderson: It says 1006.

Ms. Tillman: I'm sorry. Is it 1006? My typo. Thank you.

Judge Henderson: It will be admitted.

(Defendants' Exhibit 1006 received in evidence.)

Direct Examination by Ms. Tillman

By Ms. Tillman

Q. Ms. Radavsky, who are you employed by?

A. The State Department of Mental Health.

Q. And can you inform the Court, please, of the nature of your position with the Department of Mental Health by job title and your responsibilities?

A. I'm the Deputy Director of Long-Term Care Services, which is responsible for the oversight and management of the five state mental hospitals, two psychiatric programs. I'm responsible for the conditional release, and Mentally Disordered Offender program, and the Sexually Violent Predator Program.

Q. Ms. Radavsky, when did you first begin working with the federal court in the *Coleman* case on compliance issues?

A. In 1998 when I became the Assistant Deputy Director, one of [757] my first responsibilities was attending and participating as *Gates* was being merged into *Coleman*.

Q. And *Gates*, *Gates* was a class action suit, of course, involving just the California Medical Facility, for the record.

At the time did the Department of Mental Health provide inpatient services to the California Department of Corrections and Rehabilitation inmates?

A. Yes, they did.

Q. And since that time of 1998 through today, has DMH provided inpatient mental healthcare services to Department of Correction inmates?

A. Yes, they do.

Q. To your knowledge, does any other entity provide inpatient mental healthcare services to these CDCR inmates?

A. No, they don't.

Q. So DMH is the sole provider of mental healthcare services required by CDCR inmates who need inpatient care?

A. That's correct.

Q. Does the Department of Mental Health receive patients from any other agencies other than the Department of Corrections and Rehabilitation?

A. Yes, we do. The mission of the Department of Mental Health is outlined in the state Constitution, and we're required to provide services for mentally ill that come in through either a voluntary or involuntary short commitment. We're responsible [758] under Penal Code 1370, Incompetent to Stand Trial, Penal Code 26, Not Guilty by Reason of Insanity; Welfare and Institutions Code 6600, sexually violent predators, and various Penal Codes, 2962, 2972, and 2974, mentally disordered offenders.

So we receive multiplicity of patients from the various superior courts within the counties of California, the Board of Prison Hearings. I service the population from the Department of Juvenile Justice within the California Department of Corrections and Rehabilitation, as well as providing services to the counties.

(Document Displayed.)

By Ms. Tillman

Q. Would you look at Exhibit 1243, please, that we put up on the screen? Was your staff responsible for creating this exhibit?

A. Yes, they were.

Q. And, to your knowledge, when was it prepared by your staff?

A. Within the last 30 to 60 days.

Q. What does this exhibit show?

A. This exhibit shows the locations throughout the State of California of our five state mental hospitals and the two psychiatric programs.

Q. Does it also show the number of inpatient mental healthcare beds provided by the Department of Mental Health to CDCR in states?

[759] A Yes, it not only shows the number, but it shows the breakdown between gender and between acute level of care, which is essentially for those patients that require immediate treatment to stabilize a psychotic crisis or those, for example, in intermediate care, which is for longer term and chronic mental illness.

Q. Will this map assist in your testimony today?

A. Yes.

Q. Looking at the map, would you describe to the Court where the Department of Mental Health provides inpatient mental healthcare to CDCR inmates within CDCR premises?

A. Okay. Let's start with the state hospitals. At the top of the box on the side where it says "Atascadero," Atascadero has 25 beds set aside for the Department of Corrections and Rehabilitation inmates. So we have 25 acute care beds and 231 intermediate care beds, which are beds for inmates that have a lower risk of violence or security. That hospital is within the city of Atascadero, close to San Luis Obispo.

Coalinga State Hospital is in Coalinga. It has a 50-bed intermediate care for the CDCR inmates. Patton State Hospital is in San Bernadino, and we have 30 female intermediate care beds.

Then the two psychiatric programs are within two prisons. So the Vacaville Psychiatric Program is within the California Medical Facility, there's 150 acute beds, which [760] right now has 20 beds dedicated for mental health crisis beds, and 150 intermediate care beds. That 150 includes a 44 bed day treatment program. Then the Salinas Valley Psychiatric program is within Salinas Valley State Prison, and currently we have 176 male intermediate care beds.

Q. Now, in regards to the programs at Vacaville Psychiatric and Salinas Valley Psychiatric Program, are those particular inpatient programs within— let me strike that.

Do those particular psychiatric programs at Salinas Valley and Vacaville Psychiatric program provide their own dining facilities for your patients?

A. Yes. Because its licensed care, they have services provided through a licensed dining and therapeutic kitchen, so they are not allowed to commingle in the other dining rooms or have food served to them by other inmates.

Judge Karlton: Ms. Tillman, may I interrupt? I have the same problem with this witness as I have with the first, although it's not as dramatic. How does this bear upon the question of whether or not overcrowding is the primary cause? Where are we going?

Ms. Tillman: I'm trying to lay a necessary foundation, Your Honor, for this witness to testify that, indeed, the mental healthcare patients that are provided inpatient services by the Department of Mental Health are not in overcrowded conditions.

[761] Judge Karlton: I see. All right. Now I understand where you are going.

By Ms. Tillman

Q. Ms. Radavsky, when you mention there is no commingling in the dining facilities, are you also indicating that there's no commingling in terms of the housing of inmates receiving inpatient mental healthcare services by the Department of Mental Health at CDCR sites with general population inmates at CDCR sites?

A. That's correct. Our patients, when they are with us, not only dine separately there, they are in separate therapeutic environments, separate individual and therapeutic groups, and they're not allowed to be out for recreation or yard time at the same time.

Q. Is any of your patients—are any of your patients triple bunked at any of your sites within state hospitals or within premises—

A. No, they are not.

Q. Under applicable state licensure requirements of Title 22, are your patients permitted to be triple bunk?

Mr. Galvan: Objection. Leading.

Judge Henderson: I will allow it.

By Ms. Tillman

Q. Are your state hospitals subject to Joint Commission Accreditation of Hospital Organization accreditation standards.

[762] Mr. Galvan: Objection. Leading.

Judge Henderson: Overruled.

The Witness: Four of my hospitals are Joint Commission accredited: Atascadero, Patton, Napa, and Metropolitan. And we do have standards for care in the living environment.

By Ms. Tillman

Q. In the course of working with the accreditation standards of the Joint Commission, are you aware of whether or not any of those standards permit triple bunking of your patients?

A. No, they do not.

Q. Are you familiar with the Court orders from the *Coleman* court concerning care provided to California Department of Correction patients by the Department of Mental Health?

A. Yes, I am.

Q. Have any of those court orders addressed the adequacy of the care rendered by the Department of Mental Health to these particular patients?

A. No, they have not.

Q. What have the orders addressed?

A. The orders have primarily requested additional beds from the Department of Mental Health.

Q. When you mention that the Court has requested additional beds be provided by the Department of Mental Health for the care of *Coleman* patients, are you familiar with the Court order [763] of March 3, 2006, which we've labeled as Exhibit 1043? And looking at page four of that court order, are you familiar with the paragraph four that requires defendants to build 64 single cells in the presently planned expansion of Salinas Valley Psychiatric Program operated by the Department of

Mental Health for Level Four violent inmates at Salinas Valley State Prison?

A. Yes, I am. And that program, the administration building has been turned over to me, and we're anticipating the housing portion to be completed and turned over by the end of December, early January '09 so that we can start occupancy either the end of January '09 or February '09.

Q. And are you also familiar with a court order of May 2, 2006, Defendant's Exhibit 1296?

The Clerk: You have five minutes, counsel.

By Ms. Tillman

Q. Again, that court order indicates not only, in paragraph seven, the addition of 36 beds for inmates at Salinas Valley State Prison, but also the addition of, in paragraph ten, 25 additional inpatient beds for inmates at Coalinga State Hospital, correct?

A. That's correct.

Q. And were those beds made available at Coalinga State Hospital?

A. Yes, they were.

Q. Looking at paragraph 11 of that exhibit, that paragraph [764] also addresses the need to provide additional beds to those inmates of the Department of Corrections who not only need inpatient services but have Level Four high custody classification, correct.

A. That's correct.

Q. In the course of your work with the Department of Mental Health, have you found that there is a wait list for beds provided by the Department of

Mental Health to these CDCR inmates in need of inpatient services?

A. The wait list is for the high security inmates that have a risk of violence.

Q. Where does that wait list usually occur, is it at your state hospitals or at the psychiatric programs within CDCR?

A. The wait list is predominantly for Salinas Valley Psychiatric Program and the high security units that we operate within the Vacaville Psychiatric Program, P2 and P3, which were opened within the last three to four years, specifically to address the wait list for these high security inmates.

Q. Why is there no wait list for the beds, the inpatient beds provided by the Department of Mental Health at places within the state hospitals like Atascadero State Hospital?

Mr. Galvan: Objection. Assumes facts not in evidence.

Judge Henderson: Why don't you rephrase, counsel?

Ms. Tillman: Thank you.

[765] By Ms. Tillman

Q. In regards to the inpatient beds available at Atascadero State Hospital, is there usually a wait list for those beds?

A. No, there is not.

Q. Do you have an understanding or have you formed an opinion as to why there is no wait list for the beds provided at Atascadero State Hospital for the care of CDCR inmates?

A. We have not received sufficient referrals to fill those beds. I have openings in the low security beds at Vacaville, Atascadero, and even for the women at Patton. So it's—-you know, the lower security folks are being treated or not referred to us.

If we get a referral and we reject it, the clinical—the Coordinated Clinical Assessment Team reviews the rejection. If there's sufficient evidence after a joint discussion by CDCR clinicians and Department of Mental Health clinicians, we will accept that and make—the final appeal decision resides with myself and my counterpart over at Corrections. If the rejection stands in the monthly report that I submit to the Special Master in the Court for bed utilization, that rejection is attached.

Q. So at the end of the day, all the rejections that stand are essentially submitted to the Special Master's team for review; is that correct?

A. That is correct.

[766] Q Do you find that mentally ill patients within the *Coleman* caseload are subject to periodic episodes of decompensation?

Mr. Bien: Objection. Leading.

Judge Henderson: I'm going to allow it. Its not prejudicial in any way. You may answer that.

The Witness: Mental illness being a metabolic and a biological disease has its ebbs and flows. It's not black and white. There are gray areas. And it's based on the stabilization of patients. Sometimes there are triggers that add to the decompensation, and that's why you have varying levels of care to meet the individual needs of patients as they stabilize or they decompensate to help get them back on track.

By Ms. Tillman

Q. How would you term the model of care provided by the Department of Mental Health?

A. The philosophy of the Department of Mental Health is to use what is called a recovery model. It's an inclusion of biopsychosocial rehabilitation and relapse prevention. It's very person centered. It treats the whole person, not just the symptoms that bring them to us for admission. So it takes us approximately 60 days to do a full admission set of evaluations from an entire interdisciplinary team.

The Clerk: Time's up, counsel.

Judge Henderson: Let me ask, is the recovery model that you just—is that a prison model, or is that in the [767] broader world outside the prison world? Is that something you've devised within the prison system? Just for my information.

The Witness: That's a good question. It started as a community basis of services and a model where traditionally mental health was a—what was called a medical model. The doctor told the team how to treat the patient. This model was started by the consumers in the community and has grown through the state mental health hospitals across the country, because it's based on the wants, the needs, and the desires of the patient with the full team in collaboration bringing every clinician to bear. You have psychologists, rehabilitation therapists, social workers, psychiatrists, clinical dieticians, because they all play a role.

Judge Henderson: Thank you.

Ms. Tillman: May I have just one last question? Thank you.

By Ms. Tillman

Q. What would enable the Department of Mental Health to better serve the mental healthcare needs of the Department of Correction inmates?

A. Additional high security beds.

Ms. Tillman: Thank you. Nothing further.

Judge Henderson: Any intervenors have any questions?

* * * *

[769] (Document Displayed.)

By Mr. Galvan

Q. Good afternoon, Ms. Radavsky. Ernest Galvan for the Plaintiffs. This is Defendant's 1243, your map. I believe you testified you prepared this for the trial. If we could zoom in to just the table of the beds for a moment? The largest set of beds are the Vacaville Psychiatric Program; is that right? The beds at CMF California Medical Facility Vacaville.

A. At this time, correct.

Q. And those are the beds that were at issue in *Gates*, those beds were there during the period of the *Gates* litigation; is that right?

Ms. Tillman: Objection as to relevance.

Judge Henderson: Overruled.

Was there an answer?

The Witness: Not all of them were.

By Mr. Galvan

Q. Those beds include a unit known as the Q unit, is that correct? Q1, 2 and 3?

A. Yes.

Q. And at the beginning of 2007, you had two suicides there toward the end of January among *Coleman* class members in the Q units, is that correct?

A. Yes.

[770] Q. Okay. If we could put up, please, the April 16th, 2007, memo?

(Document Displayed.)

Mr. Galvan: Thank you.

Judge Karlton: What exhibit is this, counsel?

Mr. Galvan: This is not an exhibit yet. We are going to offer this as a rebuttal impeachment exhibit. It will be number P588. I have copies for counsel. May I present one to the witness?

Judge Henderson: You may.

By Mr. Galvan

Q. Ms. Radavsky, are you familiar with that report?

A. Yes, I am.

Q. The document P588, did you receive a copy of that report when it was issued?

A. I didn't hear the end of your question.

Q. Did you receive a copy of that report,

Judge Henderson: When it was issued.

The Witness: Yes, I did.

By Mr. Galvan

Q. For the record, this is—the report describes on the title "the suicide report of inmate," and I've redacted the name. I'll just refer to him as D.M. This is one of my clients who died in the Q unit at Vacaville, according to this report, January 27th, 2007. I would ask you to please turn to [771] page—the page after the cc if you would, page three, the one that starts: "Memorandum to Susan Hubbard" at the top it's page one of the actual memorandum, one page in from here.

And the body of text there in the memorandum describes the circumstance under which D.M. died, you'll see there, the first sentence:

"An order for one-to-one direct visual observation for the purposes of suicide watch was in effect."

And it says there.

"He has smeared feces on the window, and then when they checked on him—"

Down at the bottom, if I can read, it says:

"M was kneeling in front of his desk with a noose around his neck,"

And describes the lifesaving measures.

If you could turn now to the recommendations page, which is page four of this same memo. And the—one page back, please.

(Document Displayed.)

By Mr. Galvan

Q. If I could ask you, Ms. Radavsky, to look at the very first cell in the table which has some text? It's a little bit obscured by the watermark. I will read it for the record.

"The Department of Mental Health administration [772] requested to have 124 cells retrofitted to remove the desks and stools, replace the beds, doors and vent and window screens."

Are you familiar with that recommendation?

A. Yes, I am.

Q. And, to your knowledge, has that cell been retrofitted as described there?

A. There's a plan developed to complete all of the retrofitting. Some of the pieces have been removed, but not all of it because we have to remove inmates from the cells in order to do this, and we've submitted a plan for the retrofit, but that has not been approved yet at this time because I was asked for further clarification on it.

Q. And is it correct that you can't remove the inmates from those cells because, if you do, you'll put your department and the CDCR to the Hobson's choice of depriving inmates who are waiting for those cells of the level of care they need?

Ms. Tillman: Objection. Argumentative. Misstates Evidence.

Judge Henderson: I will allow it.

The Witness: From my point of view, I can't remove them because the Court has not allowed me, and I have been directed by the Court that all plans and changes in the Vacaville site program must occur upon approval of the Court.

[773] By Mr. Galvan

Q. Didn't the Court make that order in order to avoid the deprivation of lifesaving care to people waiting for those beds?

Ms. Tillman: Objection. Calls for speculation.

Judge Henderson: Sustained, unless you can lay a foundation.

Judge Karlton: I don't know what I said at the time I did it so—

Mr. Galvan: Thank you, Your Honor. I'd like at this time to switch the document to the April 20th memo, the one that was up before, the report of R.M. this is also an impeachment rebuttal exhibit that will be numbered for the record P589.

May I present this to the witness?

For the record, what I presented to witness will be numbered P589, and it's titled "Suicide Report Of Inmate," and again it's been redacted to protect the privacy of R.M. and surviving family in accordance with the protective orders in this case.

R.M. was another client of mine. It says here he committed suicide in the Department of Mental Health in Vacaville January 28th, 2007.

Judge Karlton: January 29th.

Mr. Galvan: I'm sorry, Your Honor. January 29th, [774] 2007.

Judge Henderson: This is two days of after the other one; is that correct?

Mr. Galvan: Yes, Your Honor. The report indicates it is two days after D.M. committed suicide in the same unit.

I would like to ask the witness to turn to page nine of the report.

By Mr. Galvan

Q. Ms. Radavsky, did you receive this report as well?

A. Yes, I did.

Q. When it was issued?

A. Yes, I did.

Q. And if you could move forward two pages, please, in the report to the page numbered nine there? If I could draw your attention to the table, the second row, first column numbered item ten. Again it's somewhat obscured by the watermark, so I will read it.

"Ten, the Department of Mental Health has been attempting to have the vents retrofitted in patient rooms since the last hanging in December 2005. The California Department of Corrections and Rehabilitation must facilitate the physical plant modifications requested."

Ms. Radavsky, you've testified you are the person responsible for these programs, is that right?

[775] A. I'm responsible for the operations and the treatment provided in these programs, yes.

Q. You are not able to, just after you leave the Courtroom today, call a contractor and have those vents redone, are you?

A. No, I am not.

Q. You are not able to do that because these so-called separate and apart DMH facilities actually are controlled by the California Department of Corrections and Rehabilitation, aren't they?

A. Ms. Tillman: Objection. Calls for a legal conclusion beyond the expertise of this witness.

Judge Henderson: Sustained.

Judge Karlton: Well, setting aside the legal question, as a practical matter, is that true?

The Witness: The Department of Corrections and Rehabilitation is responsible for the physical plant modifications.

By Mr. Galvan

Q. And the beds that we are discussing here, the beds in the Q unit, these are part of what's known as the Acute Psychiatric Program; is that right?

A. That's correct.

Q. They use the acronym APP?

A. That's correct.

Q. Is it fair to say these are the highest levels of care in [776] the system—in your system of care for CDCR inmate patients?

A. In my system of care, that is correct.

Q. And as the highest level of care, is it fair to say these are the scarcest and most available beds—I'm sorry—beds most in demand?

Ms. Tillman: Object. Vague and ambiguous.

Judge Henderson: Overruled. Are these the beds most in demand?

The Witness: Not according to my waiting list.

By Mr. Galvan

Q. According to your waiting list, what are the beds most in demand?

A. The high security beds at Salinas Valley Psychiatric Program.

Q. Would it be fair to say that these APP beds are in such high demand that you're forced to operate them in this state of—in the state that they are in now, not retrofitted?

Ms. Tillman: Objection. Misstates evidence already provided by this witness.

Judge Henderson: I will allow it as a question—as an appropriate cross-examination. You may answer that.

The Witness: Well, as I stated earlier, we submitted a plan to the Court, and I have been asked to add some clarification, which has since been added to the plan. So I'm pending a response.

[777] By Mr. Galvan

Q. I'm sorry. You are pending a response from whom?

A. I submitted a retrofit plan in order to start the retrofitting of these cells, with so many cells at a time coming off line, and Special Master Lopes asked me to add some clarification and answer some questions for him, which has recently been provided.

Q. Did you at any time call Special Master Lopes and ask for permission to accelerate the retrofitting?

A. It was included—not accelerating, but in the original request. That's why we submitted the plan.

Judge Henderson: A request for acceleration was in the original submission?

The Witness: No, sir. A request to take approximately four cells off line at a time in order to have four cells retrofitted at a time so there would be four less beds available for an acute psyche patient.

By Mr. Galvan

Q. Do you know what the current size of the waiting list is for those beds?

A. For the acute psych program?

Q. Yes, ma'am.

A. As of yesterday, it was three.

Q. At this point, I would like to turn to Defendant's exhibit 1175, which is the—titled, "July 16th, 2008, Mental Health [778] Bed Plan," and it has an attachment C at page 29.

Ms. Radavsky, are you familiar with this chart, this table?

A. I'm sorry, Counsel. Could you repeat this question?

Q. Ms. Radavsky, are you familiar with this chart or table?

A. I'm trying to see the bottom to see what document this was in.

Mr. Galvan: May I present this to the witness?

Judge Henderson: You may.

The Witness: Yes, I have.

By Mr. Galvan

Q. If I may direct your attention on this chart to the second row from the top, which I presume will be much easier to see, I think—

Mr. Galvan: I apologize, Your Honor. This chart is buried within that exhibit. It's approximately—it's about 29 pages in, Your Honor, after the text, the body of the text.

By Mr. Galvan

Q. Does the second row there, Ms. Radavsky, refer to this project of the Q1 through 3 and S2 renovations we have been discussing?

A. Yes, it does.

Q. And under "status" do you know the significance of, "April '8 to August 2009," does that mean that's the period during which the project will be built?

[779] A. That's my understanding of the status chart, because it was supposed to be coordinated as the additional crisis beds came on line at CMF.

Q. And the comment that reads, "project pending full activation of the MHCB," mental health crisis bed, "per request of the *Coleman* Special Master," does that reflect the status of the project at the time that you prepared this bed plan report?

A. That was the status at the time.

Q. And isn't it true that the project was pending activation of the MHCB because those beds, the beds you would have to take off in order to retrofit them, were needed for mental health crisis bed acute patients?

A. That's correct.

Q. If we could go back to 1243, the map, please—I'm sorry. Actually, one—if we could go to P159, exhibit P159? P159, please. Thank you.

(Document Displayed.)

Mr. Galvan: This is, for the record, Plaintiff's Exhibit P159. It has a Bates number E-Priv 183396. And if we could go back to the full document?

By Mr. Galvan

Q. Ms. Radavsky, this is a memo on your letterhead; is that correct? I realize this is another one that's hard to read.

A. That's correct.

Q. And it's addressed to J. Michael Keating, the Special [780] Master in this case?

Judge Karlton: *Coleman* Special Master.

Mr. Galvan: *Coleman* Special Master.

If we could go to the second page, please, of P159? It's actually the last page, page four, that I would like to look at, of P159. If we can go to the last page? If we could make the text big enough to read? May I present the witness a paper copy?

(Document Displayed.)

Judge Henderson: You may.

By Mr. Galvan

Q. Is it correct, Ms. Radavsky, that—well, first, I want to ask you, who is Victor Brewer, the person who signed this?

A. Victor Brewer is the Executive Director of both the Vacaville Psychiatric Program and the Salinas Valley Psychiatric Program.

Q. And he works for you; is that right?

A. He works for me.

Q. To send a memo like this to the Special Master in the *Coleman* case, he would need your permission; is that right?

A. That is correct.

Q. Isn't it true the purpose of this—of sending this memo was to seek assistance from the Special Master over a conflict in the use of the beds in the S1 unit, a conflict between two definitions that those beds could serve?

[781] A. The purpose of sending the memo was to request some guidance about—you're correct—conflict over the various mission of a mental health crisis bed versus the mission of an acute psych bed because a mental health crisis bed is ten days or less.

Q. And to be clear, when we talk about the S1 unit, the beds that are the subject of this letter, we are talking about your beds, not the CDCR's beds? The DMH beds?

Ms. Tillman: Objection. It's vague and ambiguous, argumentative, misstates evidence.

Judge Henderson: Overruled.

The Witness: Those are the beds operated by the Department of Mental Health.

By Mr. Galvan

Q. And I believe the letter—the letter will help us explain to the Court what the conflict is. If we could zoom into about the sixth line down that has the word "however" toward the middle. Mr. Brewer wrote:

> "However, if it is determined that the Appropriate LOC," level of care, "is to transfer the patient from mental health crisis bed to an app bed, the question arises, is MHCB patient to take priority over the current patients on the APP wait list. If this is the direction of the Special Master, if this is the direction the special master elects to take, [782] then the negative aspect is that any patient

> in the MHCB within VPP," Vacaville Psychiatric Program, "will take priority over the current wait list which will result in additional days before the non-Vacaville psychiatric patient mental health is many crisis bed patients will be admitted to the acute psychiatric program."

Q. Now, the conflict that Mr. Brewer is talking about there is that you've got more than one person calling on one bed; isn't that right?

A. Yes, with the mission that we were asked to take by setting aside 20 of the APP beds for the mental health crisis beds, I think part of the question also called to protocol because, being the acute beds that are the patients with the most severe mental illness, they're the folks we want to expedite in the quickest.

The question that we were asking was, did an MHCB patient, if you had a patient going into another bed, bump the acuity of the acute patient?

Judge Karlton: The point is, you wouldn't have any bumping problem if you had enough beds, right?

The Witness: Correct.

By Mr. Galvan

Q. If we could just look at the second paragraph, what Mr. Brewer wrote, his final sentence:

> [783]"the simple fact is the bed shortage places both CDCR," California Department of Corrections and Rehabilitation, "and VPP," Vacaville Psychiatric Program, "in the current operational dilemma."

I would like now to skip back to 12—switch back to 1244 which is the map 1243, I'm sorry 1243, the map in color. D-1243. Thank you.

Ms. Radavsky, we've discussed Vacaville, and just now, just talking now about the facilities operated, or as you say in the chart, co-located in the CDCR facilities, I would like to switch now to Salinas Valley Psychiatric Program, the last category. And is it correct to say that there are 176 male intermediate care facility beds in that program?

A. Yes, there are.

Q. And is it your testimony that every single one of those beds provides care that is not impacted by overcrowding in this—alleged overcrowding in the CDCR?

A. They're not impacted because they're separate from the general population, and I provide licensed care in there, so I cannot double or triple bunk those patients.

Q. So it's your testimony that you operate every single one of those 176 beds independently from the CDCR?

Ms. Tillman: Objection. Argumentative, vague.

Judge Henderson: Is that your testimony, or is it not your testimony?

* * * *

[796] Judge Henderson: It was ruled on anyway. Don't worry about it.

By Mr. Galvan

Q. You are not responsible for the administration of the care they receive while they are on the waiting list, are you?

A. No, sir, I'm not.

Q. Has anyone ever shown you the lists that some of the institutions keep of the status of those men on the waiting lists?

A. I've reviewed them, and my staff review them weekly—with my staff at Salinas Valley. My headquarters staff review them with my staff at the prison, and they make calls on those gentleman that are there.

Mr. Galvan: P583, please.

(Document Displayed.)

By Mr. Galvan

Q. Going to look at an exhibit that we have offered as P583. This is a redacted list. Okay.

Let me turn back to ASH, Atascadero State Hospital, that is, I think you've testified, a truly stand-alone state hospital, near but not on the grounds of a prison?

A. That's correct.

Q. Isn't it true that the Department of Justice monitors found in 2006 that you engage in a practice called overbedding at Atascadero?

[797] Ms. Tillman: I'm going to object. It's vague and ambiguous as to Department of Justice monitors. If you could identify which agency? I believe it's department—United States Department of Justice.

Mr. Galvan: I'm sorry. I meant to say United States. I'm sorry.

Judge Karlton: Is that true, ma'am?

The Witness: They essentially have indicated that there was some overbedding in the state hospitals.

By Mr. Galvan

Q. Isn't overbedding the practice of attempting to care for more patients than you have staff for?

A. It's not care for more patients than you have staff for. It's putting, you know, more people in than licensed capacity.

Q. Isn't it true in January 2007, you sent a letter to then Special Master Keating saying you had to restrict admissions to ASH, to Atascadero State Hospital?

A. That is correct.

Q. And isn't it true in the letter you reported to Special Master Keating that, as a result of the restriction of admissions, there were three men who had been cleared for care, in transit, already on the way there, and had to be turned back?

A. I don't have the letter in front of me, and that's possible.

[798] Mr. Galvan: If we could look at P257, please?

(Document Displayed.)

Mr. Galvan: Might I present the witness with this? P257.

The Witness: Thank you.

By Mr. Galvan

Q. P257, is it correct, is your Declaration of Cynthia A. Radavsky in Support of Defendant's Response to Plaintiff's Motion for Emergency Relief regarding Defendants' Denial of Access to Inpatient Psychiatric Beds in DMH State Hospitals?

A. That's correct.

Q. If you turn to—it only has one exhibit, Exhibit A. This is a copy of your letter to J. Michael Keating; isn't that right?

A. That is correct.

Q. You wrote here:

> "This letter is to officially notify you that the Department of Mental Health long-term care services has received information from Atascadero State Hospital that necessitates immediate restriction of admissions due to staffing limitations."

A. That is correct.

Q. If we skip down to the second paragraph, about one, two, three, four, five, six, seven, eight, nine lines, nine lines from the bottom: "an example of this occurred January 18th, [799] 2007," about five days before you wrote the letter, "when three inmates were denied admission to ASH," Atascadero State Hospital, "although the sending institution was informed of the admission restriction early in the a.m., these inmates were already in transit, recognizably an unfortunate situation for all parties." Is that correct?

A. That's correct.

Q. If we could go back to the map, which is defendant's D1243? This is the color map, State of California. So Atascadero State Hospital, you went through the numbers in your direct testimony, male acute beds, 25; mail ICF beds, 231; total of 256. Is it your testimony that you are caring for 256 CDCR inmate patients there?

A. No. Those are the beds that are dedicated. If we receive the referrals, those are the beds that I have committed we would provide services for.

Q. If I represented that the last monthly report I saw had 147 men in those beds, would that seem right?

A. That would probably be accurate.

Q. Okay. And so the balance, more than a hundred beds, 109 beds, those are empty, just waiting for patients?

A. No, they are not.

Q. I'm sorry. Those beds are not available for the *Coleman* class members?

A. Those are very valuable resources within the state of

* * * *

[808] met with on these issues?

A. Yes, it was.

Q. Were you satisfied with the outcome of those discussions?

A. Very.

Q. There's also been mention made of some of the wait lists. Has the Department of Mental Health engaged in any activity with or even without the Department of Corrections staff to address the wait list issue?

A. We've made numerous attempts at ensuring the forms are streamlined, that clinicians have been trained on both sides of the house, that we've made joint visits so that the mental health clinicians could see the environment that the patients were coming from, and that the corrections clinicians could see the environment and the milieu that the patients are in when they're with us so we could share treatment modalities and try to maintain stabilization once patients are moved back to Department of Corrections.

Q. Would it be correct to say that—let me strike that.

Do you also have a working relationship with the *Coleman* Special Master?

A. Yes, I do.

Q. And how would you describe how that working relationship is conducted?

A. Well, I think the *Coleman* Special Master and his experts raise issues to us that we take very seriously. We do [809] population management for the state hospitals, and in a recent discussion he mentioned to us that we might want to separate and do population management for the Department of Corrections inmates, which we started.

We met with him and then on Tuesday afternoon identified the group of forensic liaisons that deal with the population and started them with weekly meetings so we could track the waiting lists when there are waiting lists and make sure referrals are moving to the appropriate place.

Q. In addition to that outreach, in regards to the wait list, the Department of Corrections and rehabilitations, have you also worked with the *Coleman* special master in regards to the activation of appropriate mental healthcare beds for the California Department of Corrections inmates?

A. Yes, I think when the initial activation of the 64 Stand-alone at Salinas Valley, the activation of P2, the activation of P3.

Q. And where are P2 and P3?

A. I'm sorry. P2 and P3 are at the Vacaville Psychiatric Unit, and those were identified and opened for high risk inmates that were on the waiting list. It was a way to help whittle down the waiting list for Salinas Valley.

Q. Have you examined the feasibility of converting space at existing state hospitals for use by *Coleman* inmates?

A. We did two studies regarding Coalinga State Hospital.

[810] Q. I believe this is in Exhibit 1158, correct? We can put that up here if you like.

Mr. Galvan: Objection to this area. I don't see how it's within the scope of cross.

Ms. Tillman: I believe there was a lengthy discussion on cross about the availability of beds.

Judge Henderson: Proceed.

By Ms. Tillman

Q. Is that the Coalinga feasibility study you were referring to, Ms. Radavsky, in exhibit 1158?

A. Yes, it is.

Q. And you have placed *Coleman* caseload patients into beds at Coalinga State Hospital, is that correct?

A. Lower custody inmates, yes.

Q. In terms of the bed plans that have been prepared in response to the needs of the mentally ill inmates of the Department of Corrections, were those bed plans submitted for approval by the Special Master in the *Coleman* case?

A. Yes, they were.

Q. On cross-examination Plaintiffs' counsel asked you questions about the closure of the Atascadero State Hospital facility in January 2007; do you recall that?

A. It was not closure. It was a reduction of admissions. Yes, I do.

Q. And when you say "reduction of admissions," what does that [811] mean?

A. It means I had to limit admissions due to health and safety concerns, and in order to maintain the licensure of the hospital until I could staff up through emergency contracts adequate staff to start admissions again.

Q. And did Atascadero State Hospital—let me strike that. Is that reduction in admissions policy still in effect at Atascadero State Hospital?

A. No, it is not.

Q. Do you recall approximately when that reduction in admissions policy was eliminated?

A. The memo went in January, and I believe March or April of that same year, '07, we were able to start admishing (sic) at our regular rate.

Q. Have you undertaken any efforts to ensure that the Department of Mental Health has adequate staffing to operate its institutions without having to do a reduced admissions policy?

A. Yes. The initial reason for the reduction in admissions was a pay increase under a *Coleman* court order for the Department of Corrections and Rehabilitation.

Q. Was that—I'm sorry. Go ahead.

A. I'm sorry. We pursued pay parity which helps draw our clinicians back and keeps us viable.

Q. Was that under your May 2007 pay parity plan? I think it [812] was admitted as Defendant's exhibit 1040. We can bring that up on the screen if you like. Just paging down there—you have it?

A. Yes, it is.

Q. And is it correct that the pay parity plan was submitted to the *Coleman* Special Master and the *Coleman* court for approval in May 2007?

A. That's correct.

Q. And was that approved by the *Coleman* court?

A. Yes, it was.

Q. Have you found that the increase in pay scales for the Department of Mental Health, mental health clinicians, has enabled any reduction in staff vacancies?

A. Yes, it helped. Although we still have some contracts in place, it has helped us with recruitment of clinicians.

Q. Has the Department of Mental Health engaged in any other efforts besides obtaining pay parity with Department of Mental Health clinicians to ensure adequate staffing for its facilities?

A. Yes, we continue to reach outside of the state of California, because it's very competitive within the state. There's a national shortage on clinicians, so we make sure we have licensed internships for all of our clinical classes, as well as fellowships for our psychiatrists. That's a very strong recruiting base from us across the country, and we don't [813] want to keep competing as much within the state, we want to draw from outside of the state and from foreign nationals as possible.

Q. Did the Department of Mental Health provide the Special Master in the *Coleman* case with a recruitment plan?

A. Yes, we did.

Q. And I believe that's exhibit 1145-2. We can page down, and—there is the recruitment plan.

(Document Displayed.)

By Ms. Tillman

Q. Is that the plan you drafted and submitted to the *Coleman* Special Master and the *Coleman* Court?

A. Yes, it is.

Q. Thank you. Since the increase in pay for the Department of Mental Health clinicians and with the implementation of these recruitment strategies, has Atascadero State Hospital—has Atascadero State Hospital implemented any reduction in its admissions?

A. No, it has not.

Q. Has Coalinga State Hospital implemented any reduction in its admissions?

A. No, it has not.

Q. Do you report to the *Coleman* Special Master in regards to the status of your recruitment strategies and the success of those strategies on any periodic basis?

* * * *

[Pages 833-1067] VOL 5

[1] UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/03/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Friday, December 2, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Katherine Wyatt, CSR 9866, RMR
Official Official Court Reporters, U.S. District Court

[836] December 2, 2008 9:15 O'clock A.M

PROCEEDINGS

Judge Henderson: Okay. Good Morning. Are We Ready to proceed?

Mr. Bien: Yes, Your Honor.

Ms. Tillman: Yes, Your Honor.

Judge Henderson: You may proceed.

Ms. Tillman: Good morning, your honors. We call Robin Dezember.

(Thereupon, the witness was sworn.)

The Witness: Yes.

The Clerk: Please have a seat.

State your full name for the record.

Judge Henderson: Okay. Before we begin, I want to make something clear on the record–and proceed as you planned, counsel–but I've read Mr. Dezember's declaration, and it will not be received to the extent that it seemed to say that the state is in compliance. We've ruled on that, and it will not be received for that purpose.

Ms. Tillman: Thank you for informing me of that, your honors. I apologize to the court. I must have left my cell phone on.

May I just step away and turn that thing off? Judge Henderson: Certainly.

[837] Ms. Tillman: Thank you.

In regards to Mr. Dezember's affidavit, may I speak very quickly to the court's comments?

Judge Henderson: Yes.

Ms. Tillman: That Declaration was submitted to inform the court of exactly the impact of overcrowding on the mental health services delivery system and whether or not the primary cause of any deficiencies was, indeed, overcrowding.

And so we wanted to illuminate for the court where we were in the past as the population existed then and where we are today as the population exists today. So it's proffered with that concept in mind.

Judge Karlton: Ms. Tillman, we've said–and everybody knows it, I hope—that all of the objections will be reserved to the end. And we're receiving everything pending those decisions. But it is important because certainly I read, and perhaps unfairly, the Dezember direct testimony—and certainly the plaintiffs read it that way, as well—as going to the question of whether or not there's a continuing constitutional violation.

And it is only in that context that we have indicated that the direct testimony will not be received for that purpose. To the extent that it illuminates questions that are properly before the court, of course it will be.

Ms. Tillman: Thank you, your honor.

[838] If there's nothing further, may I proceed with the examination?

Judge Henderson: You may.

Ms. Tillman: Thank you.

I'd like to approach the witness and provide him with a copy of that trial affidavit. We've marked it as trial exhibit 1007.

Judge Henderson: You may do so.

Thereupon–

Robin Dezember

Was called as a witness on behalf of the defendants, and after having been first duly sworn, was examined and testified as follows:

Direct Examination

By Ms. Tillman:

Q. Good morning, Mr. Dezember.

A. Good morning.

Q. Would you please inform the court of your present employment in terms of its job title and job responsibilities?

A. Yes. And my name is Robin Dezember, R-o-b-i-n, D e z e m b e r.

My present title is Chief Deputy Secretary Correctional Healthcare Services Division of the Department of Corrections and Rehabilitation.

Q. Is it correct that you served previously as an [839] undersecretary of the youth and adult correctional agency from 1982 to 1986?

A. Yes, that's correct.

Q. And during that time how many prisons were built?

A. Yes, some were built. We began a program that built a lot of prisons even thereafter.

Q. And to the extent that prisons were built during your tenure as undersecretary of the youth and adult correctional agency, did staff pay attention to creating spaces to house separately, to separate house and treat the mentally ill inmates?

A. At that time, no.

Q. As we sit here today have there been changes in how the mentally ill inmates are housed and treated?

A. Well, over the years since this case began, which I think was 1995 when the order came out, there have been a lot of changes not only in process and procedures, but in retrofitting the interior spaces of the prisons to accommodate the necessary elements of mental health treatment for the population. That has gone on for years as the population grew.

Q. And has the Coleman special master had a role in those changes to the prisons to enable space to be provided to the mentally ill inmates for treatment and housing purposes?

A. Yes, he's always had a role.

Q. And how would you describe that role?

* * * *

[841] others may not?

A. Yes. The desert prisons they are there to identify need, treat for short-term, if necessary, but transfer an inmate to a place where they can get the services they require. And then, some of the prisons have a fairly extensive mental health program.

Q. Where the map indicates inpatient beds, like intermediate care and acute care enhanced outpatient program beds, are those mental healthcare beds in housing units separate and apart from general population beds, housing general population units?

A. Yes. The higher levels of care are anything we would call enhanced outpatient and above.

Q. Now, when you mentioned that many of the present housing spaces and clinical treatment areas provided for the treatment of mentally ill inmates were from retrofitted interior spaces, does that mean that cells that might have been used previously by the general population may have been somehow retrofitted?

A. Yes.

Q. Are clinicians' offices sometimes placed inside retrofitted cells?

Mr. Bien: Objection, leading.

Ms. Tillman: Pardon me?

Judge Henderson: Overruled.

The Witness: Treatment spaces and clinical office spaces, as we lump together treatment and office space, those [842] are always provided in–subject to the conditions available.

We have in some cases constructed new facilities. In many of the retrofitted facilities, the clinical spaces are acquired where they can be acquired, and people operate out of those.

By Ms. Tillman:

Q. Is it your understanding that adequate care can be rendered in these kind of make-do arrangements?

A. In my opinion, yes.

Judge Karlton: The objection that it's beyond the scope of his expertise is well-taken. I know that's just what you were going to say, Mr. Bien.

By Ms. Tillman:

Q. Have you ever received any report from the special master in the Coleman case indicating that this retrofitted space for either offices for the clinicians or for housing the mentally ill inmates was somehow not appropriate for the purposes?

A. Yes.

Q. And in terms of the Coleman special master, has the Coleman special master ever indicated that any licensure standards would be waived so that clinical space and housing space could be provided to the mentally ill?

A. That has occurred in one instance that I'm aware of.

Q. And where was that?

A. That was at California Men's Colony in what is called

* * * *

[852] the Last big piece.

And if we could continue the momentum that we have now and have the facilities to operate in, then I think we would have a sound system.

Q. Thank you.

Ms. Tillman: nothing further.

Judge Karlton: Is there anybody else?

Ms. Wang: No further questions, your honor. Cross-examination

By Mr. Bien:

Q. Good morning, Mr. Dezember.

A. Good morning.

Q. You just explained to the court what you explained to my associate in your deposition, that you don't believe that overcrowding is the primary cause of the ongoing constitutional violations in medical and mental healthcare; is that correct?

A. In mental healthcare.

Q. You're not expressing any opinion about medical care?

A. I'm not.

Q. In your witness statement in paragraph one, you referred to the alleged overcrowding of the CDCR population. Do you agree with the governor, who has declared a state of emergency based on overcrowding, that the CDCR prisons as they currently exist are extremely overcrowded?

A. Yes. I don't know about the alleged, if it's there, I'm [853] not sure. But I don't know anyone who denies that our prisons are overcrowded, and certainly not me.

Q. So if you put that in a statement it should be removed, paragraph one? You agree it's overcrowded, right?

A. I would have to look at paragraph one. Is it in here?

Q. It is.

A. Would you like me to go there? All I'm saying is my testimony is that I concur that the prison system is overcrowded.

Q. And you agree with the governor's proclamation that there's an extreme level of overcrowding that justifies a declaration of a state of emergency due to overcrowding.

A. Well, I don't assess states of emergency. But I can't state more clearly my belief that we are terribly overcrowded in our prison system.

Q. In paragraph 7 of your declaration of your witness statement, you say that you understand that this three-Judge court is convened to address the issue of CDCR's overcrowding and its impact, if any, on the delivery of mental health services to CDCR inmates.

Do you agree, Mr. Dezember, that overcrowding is having an impact on the delivery of mental health services to CDCR's mentally ill population today?

A. It has to have an impact. What I'm saying is I don't think it's a primary cause of the difficulty in delivering service.

[854] Q. So you agree that overcrowding does impact the delivery of mental health services on CDCR's inmates population today?

A. In some cases, yes.

Q. In what cases?

A. Well, in an overcrowded system you may have more difficulty with transportation from one location to another. We don't have a—you know, I can't think of very many others. But I would simply say as a reasonable human being if you filled this courtroom with 500 people, we would all be a lot more uncomfortable. And it may be even worse than that.

So I'm not offering an expert view here. I'm offering my view as a government official for all these years.

Q. And is it your view—I just want to make it clear what your view is.

Is it your view as a government official that overcrowding does not have an impact today on the mentally ill?

Ms. Tillman: Objection, asked and answered.

The Witness: I'm not saying—

Judge Henderson: I'll allow it.

Proceed.

Judge Karlton: You may answer, sir.

The Witness: I'm not saying it doesn't have an impact. I'm saying it's not the primary cause of the problems. And I also connect that to the logic of a potential solution, because in my view if you look at overcrowding and you say:

> [855] "Well, how do we solve overcrowding?" Well, one way is to cut the amount of people in the prison system. And if you do that, is that going to have an ameliorative effect on our ability to deliver healthcare, mental healthcare to the inmate population?"

And to the degree we look at the higher levels of care where we have focused most of the attention of this case over the years, I don't think it has an appreciable effect on that.

We're still going to need to provide care to a large number of those in the caseload population of EOP enhanced outpatient care and above.

If an order of this court, for example, were crafted to say those people are released, well, then, obviously it would have a significant impact on our demand for services.

But I don't think that's the kind of order that is responsible in a situation like this.

By Mr. Bien:

Q. Can you separate—are you unable to separate whether or not overcrowding is the primary cause from your concern about the type of order the court should issue?

In other words, focusing simply on the question: is overcrowding harming mentally ill prisoners of all types in [856] todays prison system, you agree that that's the case?

A. Overcrowding has negative effects on everybody in the prison system: inmates and staff, mentally ill not mentally ill, medical, all of them. Those I could certainly say yes, that's correct. That has a negative impact.

I think there's a great distinction between whether it has a negative impact and whether it is the primary element of the problem.

Q. You've testified that overcrowding is not the primary cause, and it's your contention, isn't it, that the cause is poor planning and forecasting by the state of California for the needs of the mentally ill population; is that correct? That's one of the causes that you believe?

A. I can elucidate those, if you like. I have indicated before that I think there has been a period of time when there has been poor management of the mental health system in California prisons, and that that has led to a situation that we're faced with today.

Q. So, in other words, California authorities, whoever they may be, did not do a good job of planning sufficient resources to address the current needs for mental healthcare and treatment space for the current population.

A. Good planning–good management would have involved good planning, which would have produced on a more gradual basis the bed plans that we have today. As the demand was recognized as [857] over a, what, responsible five-year planning period. As far as I can tell in recent times that was only initiated in about 2006.

So for some period of time there was a lack of attention to solving the problem of treating the higher levels of mentally ill.

Q. Well, when the prisons were built–and you personally were involved in the effort of this massive prison construction in California in the '80's; isn't that correct?

A. That's correct.

Q. You were first part of the administration that authorized the building, right?

A. Yes.

Q. Okay. And then, you moved over to Kitchell, the company for seven years that was in charge, was the general contractor that actually built those prisons.

A. Well, Kitchell wasn't a general contractor. It was a management–capital expenditure management company that I was associated with for seven years.

Q. And during that time isn't that what they were–one of the things you did with Kitchell was to help them work on the project of building this massive California prison construction.

A. By the time I was there, the prison construction program was pretty well underway. And Kitchell does a lot of different [858] kinds of work. So, I was in charge of the office, and we were responsible for school construction, other public building construction. And certainly Kitchell was a program manager of the Department of Corrections in the prison business.

Q. And you had some responsibility for that, too?

A. Yes, of course.

Q. And those are the prisons that were built without adequate medical treatment space and mental health treatment space; is that correct?

A. We had–they had treatment space. They had adequate treatment space. There was no forecast at that time of this demand we're dealing with today.

Q. So it's correct that they were built for treatment space

For medical care based on design capacity of a hundred percent and not based on the current use of those prisons at close to 200 percent?

A. Well, they were designed–let me put it this way: they were designed specifically for prison population. It was a legislative declaration that required them to be overcrowded individually, as individual prisons were authorized by the legislature.

What we attempted was to design prisons with a design capacity. We had not started out saying:

"We want to put 200 percent population in here."

[859] That evolved over time and largely came out of legislative enactments.

Q. Be that as it may, today we have close to 200 percent capacity in prisons that were designed for a population of a hundred percent.

A. That's correct.

Q. And as a result, you agree that there is a shortage of treatment and office space for medical and mental health clinicians who need to do their work to provide care to the prisoners in the prison today?

A. Well, there is a shortage of what you might call "appropriate space" for them. We certainly have them. We have–it has not prevented us from increasing the ranks of our treating clinicians. They are operating in conditions that I would prefer be improved. And definitely we would plan to do that as part of this building program that we have.

Q. As of today, Mr. Dezember, you agree that it's inappropriate to place clinicians in converted toilets as their offices.

A. I've agreed to that already in my deposition –

Q. Okay.

A. More than once.

Q. Okay. We showed you pictures, and the court has seen these pictures.

You agree that is inappropriate office space.

[860] A. Yes.

Q. And you agree it's also inappropriate to be providing mental healthcare to prisoners in non-confidential spaces.

A. Yes.

Q. Yet that is what is going on today in many of your prisons; is that correct?

A. That's exactly right. It's part and parcel of delivering a major mental health program, probably the largest mental health program in a single location in the world, and delivering that inside a prison system.

Q. And you have said that one reason–overcrowding is not the cause. The other cause is that there's been insufficient management recognition of the growing problem, the increasing prevalence rate of mentally ill.

Is that one of your alternative explanations for the problems we have today?

A. Well, it's certainly–in this situation there are cumulative causes, and that's one of them.

And when I talk about management, now, I don't talk about local management. You have to have that. You have to have local management in the prisons. You have to have a central office headquarters management structure. There were deficiencies there.

But we also–the resources need to come from where the resources are generated, and that's the legislature. So

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[862] we had mental health focused in three institutions only. And we did follow consultant advice in setting up the disbursed mental health system that was the result of our–what we called our mental health service delivery system –

By Mr. Bien:

Q. But despite—

A. –Put in it every prison.

Q. Despite listening to those consultants then, something happened between, right? Between 1995 and today, you lost track of forecasting for the growing population; is that correct?

A. I'm looking at a period of time maybe for eight or nine years prior to 2006, maybe seven or eight years where there seemed to be a lack of continuous attention to this program.

Q. And that was the time when you were not there.

A. And I was not there as a responsible official, but I was called back from time to time as a consultant myself.

Q. Whatever–my point is, you know, something happened in the past that's resulted in today's problems, right? Right now you agree that we need a massive construction program of new high-level intense beds to meet the needs of the population; is that correct?

A. Yes.

Q. And you agree we need a program to go prison by prison and build adequate treatment and office space to provide care for [863] the prisoners who are still in the prisons?

A. Yes, for those prisoners who are still there who are mentally ill patients.

Q. And the reason is that right now today the department has insufficient treatment and office space to provide for the needs of the current mentally ill population?

A. I'm not saying that. I'm saying that–

Judge Karlton: Let me just drop the word "appropriate" in there, and I think it ends this debate.

The department presently doesn't have sufficient appropriate office and treatment space.

The Witness: That I could say is correct.

By Mr. Bien:

Q. Isn't it correct, Mr. Dezember, that historical perspective that you have given your testimony here, someone who was there for a long time, you've gone in and out of government, is really an explanation for why we're in the current state of affairs we're in today, but not an alternative cause of the problems?

Ms. Tillman: I'll object. Vague and ambiguous.

Judge Karlton: I didn't understand the question, either. I agree with Ms. Tillman. I don't know whether you guys did.

Judge Henderson: I agree with you.

Mr. Bien: I'll take your guidance and try again,

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[880] The population, do you?

A. No, I don't.

Q. Okay. And so you don't know whether or not those orders may include mechanisms that would benefit all parts of the Coleman class?

A. Well, depends on what you mean by "benefit" at that point.

Q. Well, you agree that overcrowding is impacting the prison system, right?

A. I do.

Q. Okay. And one way overcrowding impacts the prison system is through increased stress, violence, which results in lockdowns in the prison system; isn't that correct?

A. It can, yes.

Q. And those lockdowns and stress impact all prisoners in the system.

Ms. Tillman: Objection, vague and ambiguous as to "stress"; calls for a possible clinical conclusion on people's care and condition?

Judge Henderson: Clarify what you mean by "stress."

By Mr. Bien:

Q. You agree that the–

Mr. Bien: I'll rephrase, your honor.

By Mr. Bien:

Q. You agree that the impact of overcrowding affects prisoners throughout the prison system?

[881] A. Um-hum.

Q. Is that right?

A. Yes.

Q. Okay. So, for example, if you're a triple C in a program and the program is locked down, that's going to affect your life. You may not be able to go to program.

A. Yes, if there's a lockdown, that's correct.

Q. And you may not be able to get access to a group, a mental health group that you might have been in?

A. Yes.

Q. So Triple C's are also affected by overcrowding. A. Yes, they are.

Q. And if there's a reduction in overcrowding Triple C's would benefit, just like everyone else.

Ms. Tillman: Objection, calls for speculation as to what reduction.

Judge Henderson: I'm going to allow it.

You may answer that.

The Witness: Well, to the degree that releasing from prison is a benefit–and I would assume in most cases it is–then, yes, they would.

Judge Karlton: Not just that. The problem is–the question is: even as to those who remain in prison, if you reduced the level of stress–and I know Ms. Tillman will object, but I'm going do use it anyhow– by virtue of

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[885] By Mr. Bien:

Q. They are going to happen. They are going to come to fruition.

A. Well, you know, we've already talked about the receiver's difficulty getting funding. This is an approved plan and it is progressing in steps and stages. And my assumption is that it will continue that way.

I can't guarantee what is going to be funded or what isn't going to be funded.

Q. You claim that you now have a good system of projecting future needs for mental healthcare. You have validated–you called it a validated system now; is that correct?

A. Yes.

Q. And that's the Navigant consultant?

A. Right.

Q. That's John Rizner?

A. That is correct, yes.

Q. John Rizner is the individual that does the work for the state?

A. He does what?

Q. He's the individual that you rely on who is employed as a consultant?

A. He's employed by navigant under their contract with the state, and he provides this function of forecasting population and bed demand.

[886] Q. And based on his–on these forecasts you have developed these bed plans which show current need and future need?

A. Yes.

Q. Okay. And you rely on those in your work and you've gone to the governor and to this court and said: "this is what we need"; is that correct?

A. Yes.

Q. And isn't it correct that the most optimistic projections of when the department will have constructed sufficient beds to meet the needs of the mental health population based on these projections is 2014.

A. I think in the bed plan that we're referring to it was 2013, but it also is addressing the population demand of that time. So this is a five-year forecast and a five-year plan that's updated annually so that you would still–you would always have a five-year look.

If you cut it off at the current bed plan, it's out at year 2013. Construction processes ordinarily somewhere in the three to five year range. But the focal point is to have beds at 2013 that meet the population expected for 2013. And all that is changeable on an annual basis.

Q. When you did that plan, the 2007 plan that you say was approved by this court, things have gotten delayed since then; isn't that correct?

A. Delayed?

[887] Q. In other words, since that plan was approved by the court, department made a decision to join in with the receiver in the 10,000 bed plan; is that correct?

A. Well, that's partially correct. There is an order of four Judges in a coordinated order that indicated that the receiver has the lead responsibility for building the 10,000 beds, which is medical and mental health.

So while we decided to do that, because it's a good thing to do, and it will fulfill the bed plan, there was also an order that said:

> "This is how you should do it."

And so we followed that.

Q. I won't go over what the order says, but I understood the order to ask the department to cooperate and work with the receiver; isn't that correct?

A. Well, there are those orders, as well.

Q. Right.

A. But this one is specific in giving the receiver the lead–I don't remember the exact–lead project authority for the 10,000 beds.

Q. Right. And you were the representative of the state of California in many meetings where the decision about whether to throw the mental health beds into the receiver's projects were discussed.

A. I have been, yes. I've been in meetings like that.

[888] Q. Okay. And you've discussed these issues with representatives of the governor's office, haven't you?

A. Yes.

Q. And are you aware of any–prior to June of 2008, are you aware of any objection the state of California has raised to any court order dealing with mental health projects, joining into the receiver's 10,000 bed project?

A. No, I'm not.

Q. And, in fact, you were–you personally testified in deposition, Mr. Dezember, that you thought that was a good thing to do to merge these projects and let the receiver take the lead.

A. Yes.

Q. And you said that was a good thing to do because by cooperating you could use the space more effectively. That was one of the reasons; isn't that correct?

A. That's one of the reasons.

Q. There's only a certain amount of space available at these sites to build. And it's better to build in an unified structure than in two separate projects.

A. Yes.

Q. Okay. And you also supported the project because you felt the receiver might have the ability to cut through some of the governmental red tape and get these things built more rapidly.

A. It appeared that way, yes.

* * * *

[894] There's some concern that the program may fold just because at some point people are not going to work for free.

The Witness: I understand that.

By Mr. Bien:

Q. Let's go over what Judge Karlton just brought to you, Mr. Dezember. Let's assume that a decision is made not to proceed with the receiver's construction program. We asked you that question in your deposition.

And you said—what would you do if the receiver's 10,000 bed program is taken off the table to comply with this, this court, Judge Karlton's orders to build mental health beds?

A. Well, the order we still have, notwithstanding the receiver's efforts, is to build the August, 2007 bed plan. That's where we would be.

Q. And how many of your staff are working on developing the August, 2007 projects?

A. Well, they are not at this point, except on individual projects, such as the preliminary planning for the 64-bed at CMF and the preliminary planning for the 50-bed at CMC and other various small projects.

What would require—what that would require if this is the result that the receiver is not going to build his facilities, the CHCF, is a shift to the August, '07 bed plan. And the projects would then have to proceed through the capital outlay process of the state.

[895] Q. Okay. And that process–we're talking about these consolidated care centers. I think that's what they are called, right, at that point?

A. Yes. Yes.

Q. And these were similar to the receiver projects in that they were efforts to concentrate in certain locations a large number of the high-level mental health beds?

A. Yes.

Q. Okay. And one of the reasons you wanted to do that was to improve your ability to recruit and retain clinicians by concentrating them in places where you might have a better chance of hiring them?

A. Yes.

Q. Is it correct that those projects, if we have to go back there, we've lost at least a year on those projects?

A. Perhaps more.

Q. When are you going to decide which project you're doing, Mr. Dezember? You have a court order to build these mental health beds. When are you going to decide whether you're going to build the August, 2007 plan or go along with the receiver's beds?

A. Well, on a gradual basis we have been on both tracks. And believe me, in government that's a difficult thing to sustain, because the attention over the past, say, 15 months has been on the receiver's building program.

[896] I don't know anyone who didn't think that was going to materialize.

So the projects that I've mentioned are part–part of the August, 2007 plan. And they are proceeding. They are not numerous projects from that plan that have been proceeding. And if that was the only thing left, then we would have to proceed with that.

Q. Have you discussed with the governor's office when the decision is going to be made about going back to the August plan or proceeding with the 10,000 bed plan?

A. I have not talked directly with the Governor's office on that. I have talked with the new Secretary of our department on a number of those issues.

Q. And what's the schedule for making that decision, Mr. Dezember?

A. I don't know.

Q. So as you sit here today, you can't represent a date certain in the future when these mental health beds that you agree are necessary to provide treatment will be available?

A. That's correct.

Q. Now, you've testified that an appropriate vacancy rate for clinicians in your area, the mental healthcare, is eight to ten percent; is that correct?

A. Yes.

Q. And today the vacancy rate is closer to 20 percent; isn't [897] that correct?

A. Well, it's today between 17 and 19 percent.

Q. And for psychiatrists it's far worse; isn't that correct?

A. It's higher, yes.

Q. Forty, 50 percent?

A. No, it's roughly 30 percent, 32 percent.

Q. Is that after you count your use of registry or before?

A. Before. When we count use of registry our vacancy is about 11 percent.

Q. Now, when you're talking about your vacancies—and you showed a chart earlier to the court—you're talking about positions that have been allocated to the department as of the date that you projected that information; is that correct?

A. Yes.

Q. Okay. And isn't it correct that the department has undertaken, as a direction of legislature and of this court, a workload study to evaluate the appropriateness of the positions it has allocated for mental healthcare?

A. Well, the workload study assesses the work required and determines the number and type of staff required to perform it. It's a true workload study.

Q. And you performed that workload study. The department performed that study?

A. It did, yes.

Q. And that was something that is part of California

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[904] we can only show established positions that the legislature has approved.

Q. Let me show you –

Mr. Bien: Can you put up, Mr. Jones, chart–plaintiffs' 245? Do you have that?

Let me–may I approach the witness and give him that?

Judge Henderson: You may.

By Mr. Bien:

Q It's a little hard to read, and I apologize for that, Mr. Dezember. This information is a little different from the information that you showed the court earlier, because it's based on the information that the department regularly provides the special master and plaintiffs' counsel in this case about your hiring and vacancies.

So this is the only information that we have access to, and the special master.

You'll see that this is taken from the monthly information that you provide, the Department of Corrections provides.

Isn't it correct that as of August of 2008 there's a 40 percent vacancy for psychiatrists?

A. According to this report, yes.

Q. And you had 955 vacant positions in August of 2008?

A. 155 what?

[905] Q. 955 total positions?

A. Oh, total. Total, yes.

Q. Yes.

A. Vacant.

Q. And so if you add in the additional positions that you've been authorized–

Judge Karlton: Not positions; proposed.

By Mr. Bien:

Q. Proposed positions–excuse me–your vacancy rate would currently be higher. In other words, you've added 400 more positions than what is shown here?

A. I believe it would be that much higher. I'm trying to think of when the budget was approved.

Q. Late September.

A. September.

Q. Right.

A. So it would jack this number up, yes.

Q. Okay. And in addition to the 400 positions, we also have these additional positions that you and the special master have decided are necessary under the workload study based on the changed assumptions we have discussed. And you haven't even asked the legislature for those positions yet, have you?

A. That's correct. They are not yet established.

Q. And before you can start actually hiring for a position, you have to go to the legislature and get them established; is

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[910] Q. And would you agree that 20 percent of the triple CMS class today is more than 5,000 prisoners?

A. Yes.

Q. So you agree that as of today, as you sit here today, November of 2008, 5,000 –

Judge Karlton: December, but who's counting?

Mr. Bien it's December now. Excuse me.

By Mr. Bien:

Q. In December of 2008, 5,000 Coleman class members are housed in what you would call "bad beds" or "nontraditional beds."

A. Yes.

Q. You've, in fact, called them "ugly beds" in a report that you wrote–helped write to governor Schwarzenegger; isn't that correct?

A. Which report?

Q. The Deukmejian report?

A. Oh, the independent review panel.

Q. Independent review panel.

A. Yes, there are euphemistic terms for them. They are bad beds. They are ugly beds. They are alternative beds. They are places where housing an inmate was not designed or intended when the place was built. And so they are gymnasiums. They are dayrooms, things like that.

Q. Are you aware of any program policy written statement that excludes triple CMS inmates from these bad beds?

[911] A. I don't think we have a written policy on that. It's a matter of cooperation between our mental health folks and the classification and housing people in the division of adult institutions.

Q. Now, I'm talking about the triple C right now. You say there's some policy?

A. No, I said I don't think there's a written policy directive on that, as far as I know. I could be wrong, but I do know as a matter of cooperative relationship, if you will, between the mental health organization and the division of adult institutions that if–that a caseload inmate is not necessarily treated by a noncaseload inmate in this regard.

Q. But 5,000 of them are there right now.

A. Well, yeah. We're 200 percent overcrowded.

Q. And I'll represent to you, and you can look at the–have you looked at the declarations of Dr. Haney or Dr. Stewart?

A. No.

Q. You understand that those are experts working for the plaintiffs in this case?

A. I understand that, yes.

Q. And they toured the prisons and studied the prisons and examined medical records and looked at these issues, and they first issued their reports in November of 2007?

Do you know that?

A. I don don't know that, no.

* * * *

[924] report–well, go ahead. I don't want to–go ahead, Ms. Tillman.

The Witness: this is–this chart demonstrates improvement coinciding, I think, with the opening of our California medical facility mental health crisis bed.

By Ms. Tillman

Q And that opened in June 2008; is that correct?

A Excuse me?

Q Did that open in June 2008?

A. Yes.

Q. Even with the opening of the mental health crisis bed unit at California Medical Facility, there appears to still be a wait list for mental health crisis beds, correct?

A. Yes.

Q And are there reasons that there still remain a wait list for mental health crisis beds?

A Well, the demand–all I can say is demand exceeds the supply of those beds.

Q And we move to page 5 of exhibit 1290. We see the Ash wait list, correct?

A Yes.

Q And ash provides intermediate care beds?

A Excuse me?

Q Does ash provide intermediate care beds?

A Yes.

[925] Q And, again, we see a marked decrease in that wait list, correct?

A Yes, correct.

Q Moving to page 7, the Salinas valley psychiatric program wait list, do we see any change in the wait list for the inpatient beds provided by Salinas valley psychiatric program over the past four months?

A Very little.

Q Why is that?

A Again, there's a large demand there that exceeds the available beds.

Q What is the demand for, exactly?

A It's for high custody intermediate care for severely mentally ill inmates.

Q And those inmates are amenable to placement only at Salinas valley psychiatric program because of their high custody status?

A For the most part.

Q In terms of the treatment and care of high custody inmates with mental illness issues, are you familiar with the use of therapeutic modules?

A. Yes.

Mr. Bien: Beyond the scope of the direct–cross. Excuse me.

Ms. Tillman: Your Honor, I wanted to get into the [926] Contrast between holding cells and therapeutic modules, if I might proceed on that basis? Holding cells were discussed on cross-exam.

Judge Henderson: Discussing and opening–go on. go on.

By Ms. Tillman

Q Mr. Dezember, Are you familiar with any differences or similarities–let me strike that.

Mr. Dezember, can you explain to the court what a holding cell is versus what a therapeutic module is?

A Well, holding cells may vary from prison to prison. It's a place where they're keeping an inmate while moving from one location to another, and it's a temporary location.

A Therapeutic treatment module is a designed–I don't know–phone booth sort of thing with a mesh–wire mesh around it. It's for the purpose of permitting one-on-one or group therapy with a clinical psychologist or social worker in a setting in which they would be at risk otherwise if the inmates were not so contained.

Q When you say "at risk," at risk for what?

A Attack. We do have staff that are attacked from time to time.

Q And when you previously testified that you rely upon the monitoring tours of the special master's team of experts to obtain information about the operations of the whole range of [927] CDCR institutions providing mental healthcare, have you received any information critical of the use of holding cells from the special master's team?

A Holding cells?

Q Correct.

A I think–you know, I can't remember specific, but my general sense is if they're used for anything more than a very short stay, they're inappropriate.

Judge Karlton: and you have been told that by the special master that's going on?

The Witness: Yes.

By Ms. Tillman

Q And have you received any reports from the special master's team critical of the use of therapeutic modules?

A Initially, yes. Although, there's been–there was a recognition that at least under the conditions we're using them they were necessary, and so the special master allowed his monitoring staff to assist us with putting together an appropriate design that would suit both the purposes of the communication with the inmate that's necessary for the therapy and also the safety of the clinician.

Q When you say "an appropriate design," what are you referring to?

A Well, we now have a standard design that we have given the prison industry authority when they build these. That is [928] a design that was concurred in by at least one or more of the special master's monitors.

Judge Karlton: Dr. Metzner approved the present design?

The Witness: Yes, Dr. Metzner was involved in that. By Ms. Tillman

Q Is the present design all that different from the previous design?

A It's somewhat different. I don't know. I can't tell you exactly what the differences are. I think it's a little roomier, more space in it.

Q To the extent that you review the special master's monitoring reports that are filed with the Coleman court, are you aware of the special master's latest 20th round report's findings as to the decreased vacancies at certain institutions?

A Well, I think as–yes, in that report, he summarizes every institution, and some discussions are faring quite well in all of the categories we're concerned about, and some institutions are not, and that includes the vacancy rates at the individual facility.

Q So, for instance, the California Institute for Women, the report indicated, quote, "achieved nearly full staffing with a vacancy rate of .018." That's at page 306 of the report. Was that a finding that you agreed with?

A I accept it. I did not go and make my own survey. I was [929] very happy to see that result.

Q And, likewise, the report indicated that at Folsom State Prison they were able to achieve full mental health clinical staffing with the exception of 75 recreational therapist. And, again that was something you were happy to see?

A Yes, yes, of course.

Q Likewise, High Desert State Prison was found to have consistent compliance with quarterly case manager contacts and annual interdisciplinary treatment team review of the clients, patients, with reception services appearing to be substantially in compliance with program guide requirements. Was that a finding that you also accepted?

A Yes.

Q And the California Institute for Men, the report indicated that all supervising clinical positions were filled. Again a finding that you accepted?

A Yes.

Q Sierra Conservation Center was reported had no mental health vacancies and remained richly staffed as to inmate/clinician ratios. Was that a report finding that you accepted?

A Yes.

Q In discussing the potential impact of a prisoner release order, you were posed various hypotheticals by plaintiff counsel. It was indicated in plaintiff counsel's hypotheticals

[933] the actual construction stage?

A It's going to be several years.

Q And during that time you'll make do with what you have?

A I can't hear.

Q During that time you'll make do with what you have?

A That's all that is available.

Ms. Tillman: thank you. Nothing further.

Mr. Bien: can you show plaintiff exhibit 585, please? First page?

May I approach the Witness?

Judge Henderson: You may.

Recross Examination by Mr. Bien

By Mr. Bien

Q Is plaintiff's Exhibit 585 a document that you receive in the course of your work as Chief Deputy Secretary?

A Yes.

Q Okay. And this is a report prepared by the healthcare placement oversight program run by Mr. Rick Johnson?

A Yes.

Q And you've testified this is some of the most accurate information you receive?

Ms. Tillman: I object to the extent this particular exhibit is after the August 30, 2008 deadline. It refers to information gathered in September 2008, I believe.

Mr. Bien: the chart they put up covered September [934] a Minute ago.

Judge Henderson: Proceed.

The Witness: What was the question again?

By Mr. Bien

Q You've testified that Mr. Johnson's department provides good, accurate information that you rely on; isn't that correct?

A Yes.

Q Okay. And this is a report on prisoners who are referred for mental health crisis beds and need assistance in getting there by the–by headquarters because they can't get to them in their own prison; is that correct?

A Well, this report does that, and other things.

Q Okay. So is it correct that in the month of September–I'm looking at the first paragraph–Mr. Johnson reports to you there were 359 referrals for mental health crisis beds, right?

A Yes.

Q And of the 359, 100 got to a mental health crisis bed; is that right?

A It says a hundred were placed.

Judge Karlton: that means they got to a mental health crisis bed, right?

The Witness: Well, I certainly assume so. It doesn't say that. I'm just trying to be accurate.

[935] By Mr. Bien

Q Okay. Then if you go down two paragraphs below, it says of the hundred transferred, 27 cases were transferred within the required 24 hours?

A Yes.

Q Okay. So of the 359 referrals in September 2008, 27 of the patients were placed in a mental health crisis bed within the required 24 hours, right?

A Yes.

Q For the hundred right before that, for the hundred that did get to mental health crisis beds, the average number of days waiting was 2.45, right?

A Yes.

Q And the program guide standard is 24 hours or less, right?

A Yes.

Q Okay.

Mr. Bien: can you show 263, please? I think I'm going to give you a copy, also.

Judge Karlton: I think we've got a copy. Maybe we don't.

(Document displayed.)

By Mr. Bien

Q Mr. Dezember, This is plaintiff's exhibit 263 that was created based on data that we receive and the special master receives from you. This very chart–this very document we [936] get from Mr. Johnson. It's also provided to us, as you know. And on the top line you'll see are the–is the referral number, the same number I showed you here, the 359. And the bottom line is the–and the bottom line is the transfer number, the same number we just discussed, the hundred transferred.

You'll note that between June and July and August there was some improvement, wasn't there, in terms of the number of prisoners that actually were able to be transfer to a mental health crisis bed?

A Yes.

Q Okay. And do you attribute that to the opening of a 50-bed mental health crisis bed facility at CMF?

A It at least had a positive impact on that.

Q And you have been subject to a court order to build an additional 50-bed mental health crisis bed unit at CMC prison; isn't that correct?

A That's correct.

Q And as of today, is that program under construction? Is there any –

A Not under construction. It is in that capital outlay process I described a few minutes ago.

Q Several years away still?

A Probably.

Q Are there any other crisis bed construction projects that

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[943] I still believe the solution to the problem is utilizing available beds that we have at Atascadero and California medical facility for intermediate care, notwithstanding custody determinations, which are now being reviewed very carefully by the division of adult institutions who make those determinations.

By Mr. Bien

Q Do you know that Dr. Packer looked at the issue of utilization management for these higher level of care beds?

Ms. Tillman: Lack of foundation. I think he testified previously he hasn't read Mr. Packer's report.

Judge Henderson: He has not read Dr. Packer's Report.

The Witness: I have not, and I haven't met him Either.

By Mr. Bien

Q Okay. You agree with the Navigant study that shows that there is a current deficit in inpatient care beds the department needs? In other words, you agree that there is a need to build more beds?

A Let me just say this: I agree I understand and agree with the Navigant information, the study, the report. I'd have to look at it to identify any details in it. But I concur in that report. It's why we hire them.

Q And you agree that the beds that you have recommended to [944] this court and the Governor that need to be built should be built?

A Yes, I do.

Mr. Bien: Thanks.

Judge Henderson: Do you have something further, Counsel?

Ms. Tillman: One question.

Judge Henderson: Do you have something?

Judge Karlton: No, I didn't know what was going on. Further redirect examination

By Ms. Tillman

Q Would it be correct to say, Mr. Dezember, that even if there is a population reduction, you'll still have to create beds, whether out of existing space or hopefully out of new space?

A That's my conviction, yes, that we will still need to build most, if not All, of the beds we're planning in the plan now. Ms. Tillman: thank you, nothing further.

Judge Henderson: Okay. Any other defendants or intervenors? CCPOA?

Ms. Leonard: No further questions.

Judge Henderson: Okay. Thank you for testifying, Mr. Dezember. You may step down. You're excused.

Let's take our lunch recess for an hour. Court's Adjourned.

[945] (Luncheon recess taken.)

Judge Henderson: Okay. Let's get going. You may call your next witness.

Ms. Kahn: Good afternoon. Jane Kahn for plaintiffs, and we would like to call back Dr. Haney.

Judge Henderson: Welcome back, Dr. Haney. You are still under oath from your previous swearing in.

Judge Karlton: You're still under oath.

Craig William Haney,

Having been called as a witness by the plaintiffs was previously duly sworn and examined as follows:

Direct examination by Ms. Kahn

By Ms. Kahn

Q Dr. Haney, in your August 2008 report, you expressed the opinion that no relief other than a population reduction order will remedy the constitutional violations in mental health and medical care. Can you briefly explain the basis of your opinion?

A Yes, I can. There are really three or four reasons why I reached that conclusion. The first one is that the alternative approaches to addressing the problems are ones that are very time consuming in nature. The kinds of problems that I identified in my report, the things that I saw when I toured the prisons, the things that are reflected in the documents that I reviewed speak to really emergency-like conditions.

[946] There are people, prisoners, suffering throughout the entire prison system, mentally ill and medically ill prisoners who are not able to get the level of care they need. They are not able to participate in programs because of shortages of staff and space and so on and so forth. Those things are urgent problems, and only a solution which can be brought to fruition quickly can address the kind of

immediate suffering which is taking place throughout the system which I saw and other experts saw as well.

The proposal–the proposals that I've looked at that identify potential solutions to this problem which involve construction of additional mental health facilities and healthcare facilities and so on, as well as construction at the present sites of the prison project timetables out to 2013, 2014, before these plans are finalized. The prisoners who were in the situations that I saw can't wait that long.

In addition, however, unfortunately, it appears to me, again based on everything that I've read in this case, that even those projections are unrealistic. So 2013 and 2014 is not only a best case scenario. It appears to be an impossible scenario for the state to be able to meet.

There have already been a series of delays in the case, not contemplated in the plans that I reviewed that project to 2014 or so, delays which involve expenditure of funds in the early stages of planning so that things have been [947] placed on hold. The receiver's beds, for example, which are such an integral part of the state's proposed solution to these problems. That plan is at about step two or three or four in what may end up being a hundred-step process and it's on hold.

I've looked at other documents which speak to relatively, one would think, seemingly straightforward kinds of small-scale remedies to immediate problems, things like creating small management yards that prisoners in the administrative segregation units need because they are not getting adequate access to exercise. And even something like that has taken a long period of time to be completed.

So a several-year process, request for the court to stay or extend the deadline in order to finish a project pales in comparison to the large-scale issues and problems that have been identified by myself and other experts.

The other reason really has to do with a frank recognition on my part that even if these plans did come to fruition and even if they were somehow miraculously done on time, or even ahead of time, they would not adequately address all of the overcrowding related constitutional problems that I saw in the system. There are plans for increasing space for only a small percentage of the Coleman class members. They don't address the way in which overcrowding is affecting 29-, or, what may be by 2013 or '14, 30,000 3c class members.

In fact, the plans that I've seen, the receiver's [948] Beds contemplate only the creation of adequate space for about 5,300 EOP prisoners, 2,000 of whom will be left in the prison system unless steps are taken to address the overcrowding which plagues that system and all aspects of that system.

Those 3c prisoners, all of whom will remain in those facilities, and the 2,000 remaining EOP prisoners will still be subjected to many of the kinds of conditions that I have been describing and other experts have talked about as well.

Those plans also, in my opinion, don't realistically address the kinds of massive increases in staffing that would need to be introduced into the system in order to respond to the kind of overcrowding-related constitutional violations that I addressed in my report and that I testified about a few weeks ago.

I guess the final issue is that I–this is a problem that I have been looking at for a long time in the state of California, somebody who studies overcrowding and how prison systems operate and function, the Department of Corrections has been talking about addressing the issue of overcrowding and the way in which overcrowding impacts mental health and medical care and other aspects of the conditions that prisoners in the system confront in pretty much the same way for almost 28 years.

The very first overcrowding case I participated in was in 1980 and there, and in each subsequent case, including a [949] case that involves a fair number of mentally ill prisoners in the California men's colony in San Luis Obispo, a case called *Donner versus Mccarthy*. Each time the proposed solution is to address an unexpected influx of prisoners whose presence in the system has created overcrowding which is undermining the delivery of services and care through a little bit better planning and more construction, and over that 28-year period of time, the system has gotten worse not better. It has gotten more and more overcrowded.

The delivery of services, with some peaks as a result of the intervention of the court and some injection of energy and resources, things have improved from time to time, but the overwhelming press of the numbers in the system is now weighting it down in such a way that this proposed solution, i think, has finally run its course, and it is time, in my opinion, to address the issue at its cause, and the cause of it is overcrowding. And until and unless overcrowding is dealt with in a direct and significant way, all of these other approaches to the delivery of services in a constitutional manner, frankly, miss point.

Q In your report, when you were discussing a population reduction order, your opinion was the CDCR population should be reduced to a level of capacity 145 percent or lower?

A Yes.

Q Can you explain how you came to that number?

[950] A Yes. Well, I would be misleading the court if I suggested this was an exact science. So this was an approximation on my part, and I specified a range within which I thought a target range, within which I thought the population—or to which I thought the population should be reduced, and I began that range with a hundred percent of the population, a hundred percent of the rated capacity of the system.

Judge Karlton: Let me interrupt you before you go on. I think I read in your direct testimony that most experts thought that 93 to 95 percent of capacity was approaching overcrowding.

The Witness: Yes, Your Honor.

Judge Karlton: How do you get to 145?

The Witness: You get to 145, frankly, by making a concession to what's practical in the immediate circumstance, and that's why I did not want to take a hundred percent of capacity off the table. There was a time in corrections when 95 percent was regarded as a system that was beginning to get dangerously overcrowded. Design capacities are established for a reason. They're established not only based on the number of cells, but also based on the amount of resources, the programming space and so on that a facility has. So these are meaningful limits.

We have been operating roughly for ten or so years in this system at almost twice what those rated capacities are [951] at. So I certainly did not want to exclude the possibility that we would move back to a point in time at some point in the future where a hundred percent of capacity or even less, assuming the system begins to function as it should, could be attained.

Now, the 145, I said, is the outside limit, the outside limit of a target, and that was based on an analysis that was done actually by another group of experts who relied on the input of a group of experienced California wardens. The court may be aware that in 2004 a group called the corrections independent review board met. It was headed by former governor George Deukmejian. There were a group of experts, many of whom employees of the departments of corrections and other experts. Mr. Dezember, who I understand was here this morning, was the chief consultant to that group.

They fashioned an estimate of what they believed to be, based on their knowledge of the California prison system, what they called a maximum operable capacity. This was the capacity that, in their opinion, the prisons could operate at safely but also could deliver programming services in an effective way.

I hasten to add they were explicit in that calculation, and Mr. Dezember has acknowledged they were explicit in that calculation, as excluding from that number the kind of treatment space that would be required to deliver

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[954] Q Is it also your testimony and opinion that remaining in the reception centers for long periods of

time can actually cause decompensation and cause patients to move to higher levels of care?

A Yes.

Ms. Tillman: objection to relevance. We already discussed it. It's been asked and answered in the course of phase one testimony.

Judge Henderson: Overruled.

The Witness: It is absolutely my testimony–in phase one testimony, Judge Karlton asked me whether being in prison in and of itself adversely affected people's mental health. I answered under ideal conditions, of course it didn't. We are talking about in this system, far from ideal prison conditions. We are talking about prisoners, many of whom are mentally ill, who come into this system and who sit in some of the worst conditions of confinement that I have seen anywhere in the united states, and they sit there not for short periods of time, but more for months on end, waiting for transfer to appropriate beds elsewhere in the system.

Many of them are transferred out of these housing units into environments where–the 3c's can go anywhere in the system, including being housed in what, again, are bad beds, psychologically and medically unhealthy environments for them to live in.

[955] Reducing the overcrowding in the system by reducing, among other things, the existence of these bad beds takes class members out of these environments and prevents their exposure to those environments from adversely affecting their mental health and from leading some of them, some percentage of

them, to decompensate or deteriorate in the face of these conditions.

Reducing the overcrowding does many other things as well. Many of the problems that affect the Coleman class members are problems that have to do with space and access to treatment. That involves space for treatment, space which is inadequate in part because it's being used for other things, in part because it is not enough space to accommodate the numbers of people who need to use it. A reduction in overcrowding will directly--will directly begin to resolve that problem.

Many of the access to treatment and access to appropriate level of care issues have to do with the understaffing that plagues the system. Much of this understaffing can only be understood in terms of overcrowding. Understaffing is also in relationship to the number of people that the staff needs are intended to address.

So, obviously, if you reduce the amount of overcrowding in the system, you reduce the level or percentages of understaffing that currently plagues the system, and that directly affects Coleman class members.

It allows them to get access to better care. It [956] allows them to move through the system more quickly because they have better and more clinical contact. It gives clinicians opportunities to make recommendations about housing that are clinically mandated, the kinds of recommendations that they're not in a position to make now, simply because there are no beds available.

The fewer people there are in the system, the fewer people there will be on the waiting lists in the system. Once the system begins to operate and functions more effective as a mental healthcare delivery system, then the level of acuity you would expect to go down, rather than going up we're looking at.

And I showed charts in my testimony in the first phase of the trial about the increase in, not only the size of the Coleman class population in general, but also what appears to be an increasing level of acuity, a larger number of mentally ill prisoners in the system and a larger number of more seriously mentally ill prisoners. I believe that is, in part, the result of the overcrowding which plagues the entire system.

By Ms. Kahn

Q Thank you. One last question.

Are you aware of any other prison systems that were able to come into constitutional compliance after they reduced the level of overcrowding in their system?

A Yes. There are a number of instances of this. I know the

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[966] Q And I think what you're really saying, isn't it, as the report stated, quote:

"A group of experienced California prison wardens told the panel at a recent forum that the operable capacity of the state's prisons to support full Inmate programming in a safe and secure environment is 111,309 inmates, or 145 percent of design capacity."

Correct?

A Yes. One hundred forty-five percent of capacity is how they defined maximal operable capacity.

Q At least how that set of wardens defined it, correct?

A How that set of wardens defined it and that figure being endorsed by the corrections independent review panel.

Q In your mind, right?

And so wouldn't you say that the 145 percent number is at best a range of appropriate capacity?

A Well, I'm not sure it's a range. It's a number. It's not a range, so I didn't see anything in the–in that report or in the logic by which that number was arrived at that suggested it was a–it was a range of numbers around which it might be possible to operate at maximal operable capacity. I suggested it to you as a range. I articulated a range from 100 to 145 percent, and also articulated why I thought 145 percent was the most generous possible estimate that was defensible, given [967] The fact that those wardens and the corrections independent review board did not take into account many of the issues that we're grappling with here, which is what kind of space is needed for a constitutionally adequate mental and medical healthcare delivery system.

Judge Karlton: Hang on a second, Dr. Haney. Now I'm even more confused than I was when I came in, which is very confused.

If 145 percent is inadequate because it doesn't represent the operable level including mental health and physical health provision, how can we–how could anybody find 145 percent adequate, appropriate?

The Witness: well, that's a very good question. What I'm assuming is we would be doing other things as well, so in addition to that, arriving at that percent of the population, that there would be other things that would be being done as well so that we would begin to approximate a much more viable overall system of medical and mental healthcare delivery.

Admittedly, a better number would be a hundred percent, but given the fact this is a system that's operated at 190 percent for a decade or so, it seemed to me it was appropriate to articulate a range that was reachable, a range at which we could begin to—we could begin to perceive the benefits of some of the modifications that had been made in the [968] medical and mental healthcare delivery system.

It's conceivable that a system operating at 145 percent of capacity in California, given the size of the population and so on, would, in fact, have to be further reduced, but it seemed to me it was a good place to begin.

By Ms. Tillman

Q You didn't participate in the discussions with the wardens that were a part of this independent review panel report, did you?

A No, I simply read the chapter that was devoted to it. I read Mr. Dezember's deposition testimony in which he discussed that meeting.

Q And you don't know what methodology or formula the wardens may or may not have used in coming to this 145 percent figure, do you?

A As it's reflected in the chapter in the discussion of how they came to that conclusion.

Q It simply says, "a group of experienced wardens told the independent review panel." There's no discussion of formula, is there?

A I think there's more discussion about what was discussed, where it was discussed, how it was discussed. And I think Mr. Dezember discussed these in his deposition testimony as well.

Q You don't know what that formula was, do you?

A I don't know the specific formula, no.

* * * *

[972] it, and I haven't looked at it."

On that basis we ask his last response be struck, Your Honor.

Judge Karlton: That's not what happens. The record is what the record is.

By Ms. Tillman

Q Do you have any opinion as to whether or not any of the released inmates, particularly release involving some 40,000 inmates, would actually receive constitutionally adequate care in the communities they're released to?

A Well, yes, I do. I think it would depend entirely on how they were released, the time period over which they were released, what kinds of changes were determined to be necessary, if any, in the resources that were available to communities where the prisoners were being released to, whether there needed to be enhancement, if any, to the parole outpatient clinics. I think all of those things would need to be determined.

Judge Karlton: Hang on a second, Ms. Tillman.

We have an obligation, in the event we reach the point where we think–the point that something has to be done in considering what has to be done to consider public safety. Unlike you, I'm not an expert, but it seems to me that it at least raises a serious question if you were to take 40,000, for example, some 20 percent of which were seriously ill, and move [973] them into the community—let me ask instead of telling you. Does that represent a threat to public safety?

The Witness: if it was done thoughtlessly without planning, without a process, then it might, not only because some percentage of them were mentally ill, but because that kind of outpouring into communities that weren't prepared to receive a very large influx of prisoners might be problematic in a variety of different ways. So I did not in my report, and I don't know anybody to be suggesting, that an immediate release of 40,000 prisoners is what is called for.

What I recommended here, and Ms. Tillman and I discussed this in my deposition, is a process by which prisoners were released—a process by which at the very least prisoners who are already scheduled to be released simply be released at an accelerated pace, an accelerated pace consistent with the resources available in the community, including resources for the mentally ill, and that, in addition, other kinds of population control mechanisms be addressed.

For example, the issue of whether or not technical parole violaters needed to be returned to prison or could be handled in some other way through some other set of sanctions; whether or not in a longer-term, some kind of sentencing restructuring needed to be redone so the population of prisoners began to be reduced over time in a way that could be stabilized rather than a one time only release of prisoners.

[974] So I think there are a variety of ways this could be done. Public safety would be one consideration. But I would continue to underscore for the court we are talking about prisoners who come out of this system anyway. Some 130,000 or 10–plus or minus 10,000 each year come out of the system.

If the Department of Corrections had started a year ago simply accelerating the releases by ten percent, that would mean in an average year instead of 130,000 coming out, 143,000 came out. That single step would have in a year eliminated most, if not all, the bad beds in the system, which are about 13,000 worth.

So there are–there are small but directed steps that can be taken that minimize or eliminate any public safety concern but which have significant impact on a seriously overcrowded system. Not taking any of them, it seems to me, is also a public safety-related issue, because the prisoners who we're talking about coming out, 130,000 of them every year, being subjected to exactly the kind of noxious and unhealthy conditions that we have been talking about. I don't think–I don't think that benefits public safety either. Not to be able to address the mental health needs and issues of a significant percentage of people who are going to be released in the long run it seems to me places public safety at risk not at benefit.

Ms. Tillman: just for the record, your honor, this expert was not designated on the public safety implications of the release.

[975] Judge Karlton: I understand.

Ms. Tillman: that was not brought up in his deposition, and he was not permitted to testify about it.

Judge Karlton: thank you, ma'am. You may proceed.

By Ms. Tillman

Q You would agree that mentally ill inmates who are released, whether on parole or otherwise, can decompensate when they are not given sufficient medication management and psychiatric support?

A Persons who are mentally ill do sometimes decompensate for a variety reasons.

Q Under the best of circumstances and under the worst of circumstances, correct?

A Yes. And as I think I said the last time, I testified much more often under the worst of circumstances, which is why the circumstances under which they're living in the prison is of such concern.

Q Wouldn't the worst circumstance be an inmate who needs mental health assistance who's not able to get it while on the streets?

A No. No, not necessarily. First of all, you are assuming that they're getting mental health assistance in the system, and for a very, very large number of them they are not.

Q Can you state to any degree of certainty that, with 140 percent capacity or 145 percent capacity, the department of [976] Corrections will be able to operate a constitutionally adequate mental healthcare system?

A No. I said at the outset of that estimate, that it was not an exact science. That's why I provided a range. I tried to defend both the bottom and upper limit to the range.

I also said repeatedly that other things need to be done, that this is–there's nothing magical about 145 percent or even a hundred percent, but that at 190 percent, in my opinion, it doesn't matter what you do, you cannot achieve a constitutionally adequate system.

And the closer to a hundred percent we get, the better we will be, and the greater the likelihood that the other things the courts have been ordering in these two cases will, in fact, significantly affect the delivery of the system and bring it into constitutional compliance.

Q Isn't it true you said in deposition that, quote:

> "I am not Judge of whether or not a system at the time we arrive at that point of 145 percent capacity (145 percent capacity) is operating at a Constitutionally adequate level"?

A Of course, it goes without saying I wouldn't be the Judge of whether or not a system is constitutionally adequate.

Ms. Tillman: thank you. Nothing further.

Ms. Kahn: nothing further.

Judge Henderson: nothing further? Thank you for

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[1] UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/04/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Wednesday, December 3, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Katherine Wyatt, CSR 9866, RMR
Official Official Court Reporters, U.S. District Court

[1072] The Witness: IRA K. Packer, P A C K E R.

Ms. Tillman: good morning, your honors. We are calling Dr. Packer this morning, who obviously is testifying from Boston, Massachusetts, via various video teleconferencing technology.

Dr. Packer's experts reports in this case are marked as defendants' trial exhibits number 1018, 1019, 1020 and 1021, and they are hereby offered into evidence.

Dr. Packer's qualifications today are set forth on his curriculum vitae, and that is attached to his report of November, 2008, which is marked as exhibit 1018. There's also a summation of his qualifications on pages two and three of that report.

Thereupon–

Dr. IRA K. PACKER

Was called on behalf of the defendants, and after having been first duly sworn, was examined and testified as follows: direct examination

By Ms. Tillman:

Q. Good morning, Dr. Packer.

A. Good morning.

Q. Since you are testifying remotely, please let us know if at any time you are having difficulty hearing us or seeing any document that is being presented.

A. Okay.

* * *

[1077] The number of inmates. And so each day that the court wanted to send somebody in, they would have a special process by which they would have a double review of the bail status, and in that way limit it to who could go into the jail. If they decided they were going to send that inmate in, somebody else had to be released on the other end.

Q. Dr. Packer, is it correct that your reports indicate that you toured prison facilities within the state of California in preparing your opinion in this case?

A. I'm sorry. I could not hear the last part of your sentence.

Q. Did you tour some 11 prisons within the state of California in preparing your opinion in this case?

A. Yes, I did.

Q. And those tours occurred in November '07 and August '08, correct?

A. July, the end of July, 2008, and November, 2007.

Q. And, in general, what did you do during these tours?

A. During these tours I met with the leadership of each Prison, including the correctional, as well as the health and mental health administrators. I toured the various settings where inmates were being housed, particularly focusing on those in the Coleman class.

I looked at ADSEG units, EOP units when they were available, mental health crisis beds. I also specifically looked at gym housing, gyms that had been converted to [1078] housing.

I interviewed correctional officers, mental health professionals, as well as inmates.

Q. Did plaintiffs' counsel attend any of these tours?

A. On every single tour there was at least one plaintiffs' counsel present during the entire tour.

Q. Were you asked in this case to form an opinion on whether overcrowding was the primary cause of the alleged deficiencies in the mental healthcare system?

A. Yes, I was.

Q. And when you formed your opinion in this case on that issue, what factors did you consider?

A. What factors did I consider?

Q. Yes.

A. I considered all the information that I obtained from my tours, as well as voluminous documents and records that I reviewed, including affidavits, special master's reports, other expert reports, reports from parole, et cetera. And looking at all of those materials I arrived at conclusions about what factors within the current system were contributing most Heavily towards deficiencies in delivery of mental health services.

Q. And what were those factors?

A. Obviously, one thing I was looking at was the impact of overcrowding or too many individuals in the system. But there [1079] were many other factors, as well, including issues such as lack of electronic medical records, lack of appropriate type of placements, both concerned with physical environments as well as programmatic elements for the most severely mentally ill people who are in the system.

I also took into account the factors such as ability to attract and retain appropriately trained mental health staff, and, again, the physical conditions in terms of space available both for housing, treatment and also space for the clinicians.

Q. Based on your review of the documents and your tours of the prison and you're interviews with various personnel within the prisons, what opinion did you form to as to whether overcrowding was the primary cause?

A. As I indicated in my report, although I–excuse me–although I concluded that overcrowding was contributing and exacerbating many of the other problems, in my opinion the most–the primary cause is that the prison system in California and many other states, now has many more acutely mentally ill individuals and at a level of more severity than had been anticipated when the prisons were built.

And as a result, the existing space and existing programs really were not designed to meet the needs of this type of population. And this has resulted in a mismatch in that individuals who are much more mentally ill are now placed [1080] in prisons that were not designed for that purpose. And as a result, it's difficult in that environment to provide adequate services absent development of new facilities, as well as new programs within the new facilities.

Q. Based–I'm sorry. Go ahead.

A. Yes, that was the main factors. There were other factors, as well. As I indicated in my report, the medical record system is a paper system, and the prison is simply not able to keep up with the amount of work and volume that's required in order to maintain an appropriate medical record system without going to an electronic process, which is not yet in place.

Q. Based upon your experience and educational background and employment background, do you have an opinion regarding whether constitutional level of care can be achieved in overcrowding conditions within a correctional setting?

A. Yes, I do.

Q. And what is that opinion?

A. My opinion is that although overcrowding exacerbates the problems in providing such appropriate care, if other changes are made in the system particularly based on my experience, very particularly in Hamden, but other positions, as well, that if appropriate facilities and programs are developed that the needs of the most severely mentally ill people can manage within a correctional facility.

Judge Henderson: Can you give us some examples of

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[1086] they can become incrementally better. And I guess I haven't gotten that far in the testimony, but I'm not also necessarily saying that just releasing prisoners would improve the situation, anyway.

By Ms. Tillman:

Q. Dr. Packer, is it your testimony that Hampden county jail and the overcrowding conditions there you were able to deliver constitutionally-adequate mental healthcare?

A. Again, I can't speak to the word "constitutionally-adequate," but I will say that we were able to provide what I considered and what others considered an appropriate level of mental healthcare.

Q. And were you able to do that with the use of certain staffing resources, programming resources?

A. Yes, but part of it was our process of how we employ our staff and programs we had. The other part I believe I already testified to is that there was some effort on the part of the courts to not send in some of the mentally ill inmates into the system.

And, frankly, in my opinion the most effective procedure we had was that we provided mental health services at the courts, and we diverted mentally ill people away from the jail. So that that had a very good impact on our ability to provide the services, even though the jail was overcrowded.

Judge Karlton: Sir, that would be under the very 1087] Broad definition of a prison release program, a prison release order. What I'm asking you–I think I what I heard you say–and it's very–you know, this is not the best way to have a conversation. But what I think I heard you say was that perhaps the most effective thing to do in the interim is to in some way divert mentally ill prisoners away from the prison.

Is that correct?

The Witness: That is what I'm saying now, and i also included in my reports.

Judge Karlton: Okay. So that to the extent that that would be under the law a prison release order, you would think nonetheless that would be the appropriate thing to do? Am I understanding what you're saying?

The Witness: Yes. Yes.

Judge Karlton: Okay.

The Witness: I apologize. When they said "prison release," I thought they were literally releasing people from the prison.

I did recommend in my report, and I'm saying that now, that efforts to divert mentally ill people from the prison in the first place I do think would be a very reasonable strategy.

Judge Karlton: Thank you, sir.

By Ms. Tillman:

Q. Dr. Packer, taking a narrower definition of a prison

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[1092] somebody actually is providing the services, I think that's doable.

But in the absence of those two elements, releasing them without adequate time to plan and without appropriate resources in the community, it's not likely to be very effective. I think they will decompensate and go right back in again, and then very little has been accomplished.

Judge Henderson: thank you.

Ms. Tillman: Thank you. Nothing further.

Judge Henderson: Thank you, counsel.

Any others from defense table have anything of this Witness?

Ms. Wang: Nothing further, Your Honor.

Mr. Mitchell: No questions.

Judge Henderson: Okay. Cross-examination

By Mr. Bien:

Q. Good morning, Dr. Packer.

A. Good morning.

Q. Dr. Packer, if you assume that crowding means that the supply for mental health services and space exceeds the existing–I'm sorry. I'm going to start that again.

If you assume that overcrowding means that the demand for mental health space and services exceeds the existing supply for mental health space and services, would you [1093] agree that crowding is the primary cause of the ongoing problems in California?

Ms. Tillman: Objection, misstates the law. Misstates the PLRA. I think that's a legal definition used in this proceeding.

Judge Henderson: I'm going to allow that. You may answer that, doctor. Did you hear the Question?

The Witness: Yes, I did. Let me make sure I understood the question.

You're asking me to redefine "crowding" to say–and say the existing resources, meaning the number of ICF'S and crisis beds and et cetera is not enough relative to the number of inmates who need those services. That if I call that "crowding," would I say that's the main cause?

Judge Karlton: Overcrowding.

Judge Henderson: Would you call that "overcrowding"?

By Mr. Bien:

Q. If you called that "overcrowding" would you agree that that's the primary cause of the problems you observed right now?

Ms. Tillman: Same objections.

Judge Henderson: Same ruling.

The Witness: Yes. But let me just be clear. I [1094] want to make sure I'm saying this right. I believe you are redefining it as being that the fact that there aren't enough ICF beds, crisis beds, acute care beds, EOP beds, given the current population, that is if that is equal to overcrowding, yes. Then, I would say that is what causes it, the primary cause.

By Mr. Bien:

Q. There also aren't enough treatment spaces in prisons. There aren't enough confidential spaces in the prisons you saw also, correct?

A. That's correct.

Judge Karlton: And there wasn't enough staff; is that correct?

The Witness: Yes, the staffing thing was much more variable. I have to be frank. At some places the staffing was better than others. And certainly there had been some improvement in the staffing over at least the time period that I saw the documentation, and even from one place to another. So that was a contributory factor.

By Mr. Bien:

Q. Dr. Packer, just to be clear, in the one system that you personally worked in that experienced overcrowding, the Hamden county, Massachusetts—it's called the house of corrections. It's typically what we call a jail; is that right?

A. It actually was both called a jail and a county

* * * *

[1100] lowered in 2007.

The Witness: No. I'm sorry. I didn't hear that, Your Honor.

Judge Karlton: This is very difficult.

Do you have any reason to believe that there was any significant change in the ratio of California to the rest of the prison population in 2007?

The Witness: No, I do not.

Judge Karlton: All right.

By Mr. Bien:

Q. You endorse the various orders of the court that require the California prison system to address the particular risk of suicide in administration segregation units; isn't that correct?

A. I'm not sure what you mean when you say I "endorse."

Q. Well, you refer to the various plans that the state is implementing in an attempt to reduce the high rate of suicide in the ADSEG units.

You're aware of those plans, aren't you?

A. Off the top of my head, I'm not particularly finding what you're saying. I don't know what page you're referring to in my report to know specifically what you're talking about.

Q. Are you aware of any plans by the state of California to address the high rate of suicide in ADSEG units?

A. I did review both the reports by Dr. Patterson and the [1101] response from the state that included those plans, but off the top of my head I couldn't agree to them at this point.

Q. Okay. You agree that overcrowding can contribute to risks that might lead to suicide.

A. In and of itself, that could be one of the factors that could contribute.

Q. So, for example, if someone was in–a mentally ill person was housed in an ADSEG unit that was impacted by overcrowding, that might increase the risk of suicide for that individual.

Ms. Tillman: Objection, vague and ambiguous.

The Witness: I'm not sure what you mean when you're saying "ADSEG units impacted by overcrowding."

By Mr. Bien:

Q. Well, for example, an ADSEG unit like the ones we visited where they were unable to provide outdoor exercise to the mentally ill inmates that were house in that unit.

Do you agree that if they couldn't provide outdoor exercise as a result of overcrowding, that that mentally ill inmate in that unit was at risk as a result of overcrowding?

Ms. Tillman: Same objections.

Judge Henderson: Overruled. You may answer that.

The Witness: Yes. If you're asking me if, indeed, someone is in an ADSEG unit, and as a result of overcrowding their ability to get out of that cell and have other types of [1102] interaction is limited, could that increase that person's risk of suicide? My answer is: yes.

By Mr. Bien:

Q. And if they are in an ADSEG unit that as a result of overcrowding there's limited access to mental healthcare, the clinicians can't see the patients in a confidential setting, would you agree that also might increase the risk of suicide?

A. Yes, in that hypothetical, again, that could lead to an increased risk of suicide.

Q. And you're aware, then, that as part of the program guide, the mental health delivery system, prisoners at the enhanced outpatient level of mental healthcare, people who are at the higher level of care are supposed to be removed from regular ADSEG units to specialized ADSEG units where they can receive 10 hours a week of EOP care.

You're aware of that requirement?

A. Yes, I am aware of that.

Q. And in the course of your tours, did you learn that the system as it currently exists is unable to meet that transfer requirement, and so you found many EOP's housed in normal ADSEG units that had not been able to be transferred to these specialized units?

A. Over the course of my tours, I did come across some EOP inmates who were awaiting transfer to an EOP ADSEG and were at this time being housed in regular ADSEG awaiting a bed space, [1103] Yes.

Q. And isn't it correct that we found–I'm saying "we" because you and I were together on several of these tours–we found some of these EOP prisoners who had been referred for transfer and had been waiting for months and months and months.

Ms. Tillman: Objection.

The Witness: I definitely remember coming across a number of inmates who had been waiting for a long period of time.

By Mr. Bien:

Q. And, in fact, wasn't it correct that, for example, at Tehachapi prison you discovered several inmates who had been waiting for transfer not only to an EOP program, but to an ICF or app program, the highest level of care, the acute psychiatric program, had been waiting for months and months and months for that transfer?

Ms. Tillman: Objection, vague and ambiguous, argumentative.

Judge Henderson: Overruled.

You may answer that, Dr. Packer.

The Witness: Yes, although let me put a qualifier. I believe you said the word "acute." The ICF was intermediate care. And that was much more problematic than the acute. There were individuals waiting to get into acute. Much more significant was the waiting for the people waiting to get into [1104] this intermediate care facility.

And as I indicated in my report, the number that they gave me when I was last there was 160 something people on the waiting list to get into the intermediate care. And that's what I saw was the biggest problem that they just weren't–didn't have enough intermediate care beds to be able to accommodate the individuals that needed to be transferred there.

By Mr. Bien:

Q. Do you recall your tour of Tehachapi prison which occurred–I think it was on July 31st or August 1st, 2008? A. I would like to look at my report in front of me. I'd be able to tell you what date that was. Tehachapi, July 29th, 2008.

Q. And isn't it correct that on that tour you were accompanied by Dr. Craig Haney, plaintiffs' expert, along with other people, including me?

A. That's correct.

Q. And isn't it correct that during the course of that tour we–at the end of the day, we visited a unit called "4a." Do you recall that? And we visited several men who were on the waiting list for transfer for DMH care?

A. To be frank, I don't remember specifically the unit. I certainly do remember coming across some men who were waiting to get in –

[1105] Mr. Bien: If the court reporter could provide Dr. Packer with exhibits we premarked as p800. These are Dr. Packer's handwritten notes of his tours.

By Mr. Bien:

Q. Maybe that will help refresh your recollection.

And, Dr. Packer, if you could turn to page–you see the page numbers on the bottom right? They are production numbers, start with "PAC"?

A. Yes.

Q. If you turn to page–take a look at 2274 and 2275, please.

A. Excuse me. 2274?

Q. And 2275. And I would like you to first confirm that those are your notes for this tour.

A. Yes, they are.

Q. Okay. And on 2275, do you recall that we visited unit 4a towards the end of the day?

A. Yes, I do. I'm looking at that right now.

Q. And if I could just–if I could indulge the court and Dr. Packer–on your notes there are some names of particular prisoners that we interviewed that were in the mental health caseload.

Mr. Bien: And if it is okay with the court, we would prefer not to refer to them by name.

Judge Henderson: That's fine.

[1106] By Mr. Bien:

Q. So if we can refer to the first inmate as inmate m, Dr. Packer.

A. Yes, I understand.

Q. And the second one is inmate l; is that okay?

A. Yes. Yes.

Q. Okay. So is it correct that–if you remember–that, first of all, that unit 4a was locked down when we visited it; is that correct?

A. I have to say I don't recall exactly which unit was locked down, but I certainly visited some units that were locked down. I don't recall this particular one.

Q. Well, turn one page before to 2274. Did you recall that we were informed that that unit had not been given any yard since April of 2008?

A. Yes, I'm looking at that now, and it does refresh my memory. That unit had been locked down for quite a long time.

Q. And do you recall what we were told by the custodial officer as to why the unit was locked down?

A. Yes. There had been a serious assault on a couple of officers, and that unit had been locked down.

Q. And we were also informed that–isn't it correct that you were informed by the officers that no yard whatsoever was being provided to the inmates on that unit since April of '08?

A. That's correct.

[1107] Q. So they had not been allowed outdoors for months.

Judge Henderson: That's what "no yard" means. The Witness: they had not been allowed into the yard, it says, since April. And it was in July.

By Mr. Bien:

Q. Now, do you recall that inmate m had been referred for inpatient psychiatric care and had been accepted by the app unit in February of '08?

A. Yes, that's correct.

Q. So he'd been accepted in February of '08, but in late July he was still here in Tehachapi?

A. Yes. The only thing my notes don't say is it was acute unit. Says he was referred to DMH, and then says he was on the waiting list for ICF, which is intermediate care units. But he was so far down on the wait list that he wasn't going to get in, and so they dropped him from the list.

Q. Okay. And is it correct that the ADSEG unit at 4a was not an EOP ADSEG unit. In other words, didn't provide 10 hours a week of services?

A. That's correct.

Q. And I think your note, if you look down a little bit, about a quarter of the way down the page, were you told by the clinicians that it was even–it took even longer to transfer a prisoner to an EOP ADSEG unit than it did to get them to a DMHICF unit?

[1108] A. I thought they were talking about this particular individual. But, yes, I think what they told me, based on my notes, is that there was a long waiting list to get into the ICF, but might be longer to get them into the EOP ADSEG .

Q. And one of the two men that you and Dr. Haney interviewed whose first name begins with m refused to come out of his cell; isn't that correct?

A. That's correct.

Q. And you attempted to interview him through the cell door. What was that like, Dr. Packer?

A. To be honest, I cannot off the top of my head recall whether it was this particular interview or not. But I did several interviews over the course of my visit, so I tried to interview people through the cell doors. I can't remember specifically this case.

Q. What was your experience in general in terms of your success as a clinician in obtaining information from an inmate talking through a cell door?

A. I can tell you both based on these tours and having been in other systems that it is simply not the way to conduct a clinical interview. One cannot ask as much detailed information, cannot interact as long. And the environment doesn't lend itself to anything other than a brief mental status assessment to give a sense of whether the person is in acute crisis or has some immediate needs.

[1109] Q. The other inmate that you interviewed agreed to come out. And where did you interview him?

A. I don't recall.

Q. If you go a little further down, do you recall that there were some–I'll use the euphemism–"holding modules" set up in an area so you could interview people?

A. Again, I certainly remember that. I don't remember this particular individual. Over the course of my visits on a number of occasions they brought somebody out, put him in one of these holding cells or modules, and I would sit right next to them and interview them.

Q. Have you made a recommendation–looking back on your report about–your December report about suicide, you made a recommendation to the Department of Corrections that they should reexamine their policy of housing in the same ADSEG unit people who are there for nondisciplinary reasons and disciplinary reasons; is that correct?

That's on page –

A. To be more precise–yes, I know. But to be more precise I recommended reexamining the policy of placing somebody in ADSEG simply because they had been the victim, rather than the perpetrator.

Q. It's your understanding that that is the policy in California right now, isn't it?

A. I actually used the word "policy." I don't know if it's a [1110] policy or a procedure, but they were doing it. I found inmates like this one who had been involved in a fight, and had been not the instigator, but the victim, and for their own safety had been placed in an ADSEG unit.

And just to be clear, my recommendation was–reading this report, was either not to put them in such a unit, or at least since they were–they needed to for safety reasons, for enhanced services provided for those individuals as opposed to the instigator, the one who started the fight.

Q. Are you aware that in response to an order of Judge Karlton, that the state brought together experts from all over the country about suicide prevention, and these experts made a series of recommendations to California as to what it can do to address the problem of suicide in ADSEG units?

A. Yes, I came across that in the course of my work on this case.

Q. And are you aware that one of the recommendations that those experts made to California in 2006 was the same recommendation that you just made to California in December of 2007?

A. I don't have an independent recall of that, but that doesn't surprise me.

Q. And you also are aware that in response to that recommendation the state said that due to overcrowding it was unable to implement this idea of separating people in ADSEG who

* * * *

[1192] David L. Thomas,

Having been called as a witness by the government was first duly sworn and examined as follows:

The Clerk: Please state and spell your full name for the record.

The Witness: David l. Thomas, D-A-V-I-D L, T H O M A S.

(Dr. Thomas appeared remotely through video conferencing.)

Ms. Johnson: Dr. Thomas's expert reports in this case are marked as defendant's trial exhibits numbers 1015, 1016, and 1017, and are hereby offered into evidence.

Also, to the court reporter in Florida, we did mail copies of Dr. Thomas's expert reports to you, as well as a copy of his deposition transcript. If you could make those available to him at this time?

Dr. Thomas's qualifications are set forth on pages 1 through 3 of his first report, defendant's exhibit 1015, and his curriculum vitae, which is attached as exhibit a to that report. We're going to summarize, highlight some of his salient qualifications.

Judge Henderson: Okay.

Direct examination by Ms. Johnson

By Ms. Johnson

Q Good afternoon, Dr. Thomas.

[1193] A Good afternoon.

Q Since you're testifying remotely, please let me know if at any time you have difficulty hearing me or seeing a document that's being presented. Okay?

A Okay. Yes.

Q Dr. Thomas are you a practicing physician?

A Yes, ma'am, I am.

Q For how many years total have you practiced medicine?

A Just under 40.

Q Are you board certified in any specialty?

A Yes, Ma'am. I am board certified by the American board of ophthalmology.

Q Do you have any formal training or experience in any other medical specialties?

A Yes, Ma'am. I was partially trained in general and chest surgery and served as a general and chest surgeon in Vietnam. And I also at one time was certified by the American board of American forensic examiners as a diplomat in forensic medicine.

Q When did you receive your medical degree and from where?

A From university of Miami in 1970.

Q Do you have any other advanced degrees?

A Yes, ma'am. I have a J.D. from Stetson university law school, and I am currently working on a doctorate in health education.

[1194] Q Are you currently employed?

A Yes, ma'am, I am.

Q What are your current positions?

A I am professor and chairman of the department of surgery, professor and chairman of the division of correctional medicine and professor of public health, all at Nova Southeastern University.

Q You mentioned you served as a physician in the military?

A Yes, ma'am.

Q And what positions do you have–or what were your responsibilities at that time?

A I was drafted and went to Vietnam, and in Vietnam I served as commanding officer of a 30-bed hospital with three or four, depending on the time, other physicians working for me. It was a general medical and surgical hospital.

Q Did you also serve in the Florida house of representatives?

A Yes, ma'am, from 1984 to 1994.

Q What committees did you serve on while you were a representative in Florida?

A Could you restate that question, please?

Q What were the committees that you served on when you were a representative in Florida?

A Okay. I served on a variety of committees, probably too many to remember accurately as we sit here. But I served on appropriation. I always served on healthcare. I served on [1195] Corrections. I served on reapportionment and a variety of other commit–natural resources. Those were ones that come to–judiciary. Those were the ones that come to the top of my head as we speak.

Q After serving in the Florida house of representatives, did you work as a correctional healthcare administrator for the Florida department of corrections?

A Yes, Ma'am. In 1994 I worked as the executive director of the executive medical director of Zephyr hills correctional institution. In that capacity, I served as a physician and an administrator, and I had about nine doctors working for me.

Q For how many years total did you work for the Florida department of corrections?

A Nine years total.

Q And you said the first position was as executive director of the Zepher hills facility?

A Yes, ma'am.

Q Can you just summarize briefly from that position until your last position what positions you held in the Florida department of corrections?

A Yes, ma'am. After being at Zepher hills for a little less than a year, I became the regional medical director for region five and had about 12 or so institutions that I was responsible for the medical care.

* * * *

[1203] Q Based on your review of Pennsylvania's healthcare system with Dr. Maue, did you reach any conclusions regarding the adequacy of that healthcare system?

A Yes, ma'am. I was relatively I was convinced they were providing adequate care, that is the inmates had access to care without real barriers. They had access to a professional medical opinion. That opinion seemed to be carried out. There didn't seem to be any barriers to that, and there seemed to be reasonable documentation that this occurred.

Q In brief, what documents did you review in preparing for your opinions in this case regarding California's correctional medical care system?

A Well, in brief is difficult. I certainly had a complete set of the Plata policies and procedures, the reports of the receiver, all the reports of the receiver, the plaintiff counsel's letters of site visit reports, court orders, and a variety of other things.

Q Dr. Thomas, in preparing your opinions for this case, did you tour any prisons in California?

A Yes, ma'am, I did.

Q How many?

A A total of eight.

Q Which prisons did you tour in preparing your opinions for this case and when?

A In December of 2007 I toured San Quentin, the California [1204] medical facility, and the California Institute for Men. In September of '08, I toured north kern, the substance abuse treatment facility, pleasant valley, saline (sic) and high desert.

Q When you "saline" did you mean Solano?

A Yes, ma'am. Solano. I'm sorry.

Q In general what did you do during your tours of these eight prisons in California?

A In general? That's all I got, in general.

Q What did you do during your tours of these eight prisons in California?

A The same things that I did whenever I was asked to evaluate a prison system. I took a look at daily, and in some cases weekend, functioning of the prison, the medical facilities and their functioning. I talked to staff. I inspected medical records. I interacted with physicians, physician providers, nursing staff, correctional officers, inmates; witnessed pharmaceutical functioning; looked at the chronic illness clinics; looked at acute care responses; looked at individual provider interactions and system functioning.

Q Does plaintiffs' counsel attend these tours with you?

A Yes, ma'am.

Q Are you familiar with the concept of preventable death in the concept of medical care?

A Yes, Ma'am.

* * * *

[1224] Q The second sentence–actually, starting at the beginning: "note must be made of the space for medical facilities in the California Department of Corrections and Rehabilitation. Because of the aforementioned culture of custody dominance, even the newest of California prisons have inadequate space for care."

A Yes, ma'am.

Q That was your testimony?

A Yes, ma'am. That's not a term of art. That's a term of common language. That implies that the newest ones I have seen. I am not certain if there are other facilities that I have not seen that are newer. But, clearly, you know, from years of having custody dominance, the facilities that I have seen did not have adequate space for patient care.

Q You agree the lack of adequate space reflects a mindset where there's simply not much thought given the needs of medical care for inmates when these spaces were constructed, correct?

A That's correct.

Q You are aware that the receiver has written that the facilities available for providing healthcare within the cdcr are woefully inadequate, correct?

A Yes, ma'am.

Q And you are aware that the receiver's turnaround plan of

[Pages 1310-1541] VOL 7

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/05/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Thursday, December 4, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Katherine Wyatt, Csr 9866, Rmr
Official Official Court Reporters, U.S. District Court

[1314] December 4, 2008 9:15 o'clock a.m.

PROCEEDINGS

The Clerk: Please be seated.

Judge Henderson: Okay. You may proceed when you're ready, counsel.

Mr. Specter: Good morning. Plaintiffs call Jeanne Woodford back to the stand to testify, your honor.

Judge Henderson: Good morning, Ms. Woodford. You're still under oath from your previous swearing in.

The Witness: Thank you. Good morning.

Thereupon–

Jeanne Woodford

Resumed the stand and having been previously duly sworn, testified further for plaintiffs as follows:

Direct examination

By Mr. Specter:

Q. Good morning Ms. Woodford.

A. Good morning.

Q. Last time you testified here you explained that you held various positions within the department of corrections, including warden at San Quentin and the acting secretary of the agency; is that correct?

A. That is correct.

Q. And while you were the warden at San Quentin, didn't san

* * * *

[1327] On parole, so that there are incentives to follow the directions and rules that they are supposed to follow.

So it really depends on the model. You really can reduce your prison population, as New York has done, and reduce crime at the same time if you're building the right model and have the attitude that you can be successful.

Judge Karlton: I'm sorry, Mr. Specter, but–Mr. Specter: go ahead.

Judge Karlton: I think at least part of what you're saying suggests that an expenditure of significant funds, both in prison and outside, as a way of directing people away from their criminal behavior towards a more law-abiding behavior, that takes apparently a lot of money.

And is there any–in your view, any reason to think that we're going to see that kind of money?

The Witness: Well, I guess I would answer it this way: it costs almost $46,000 per year per inmate now. And building incentives such as work time credits or more participation credits doesn't have to cost more money. I mean, there are certainly programs available to inmates inside the prison system.

And if you're sending them out and keeping them in the communities, that's much cheaper. I believe that the chief probation officers' association of California has said that it would cost about $10,000 per year per individual to provide

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[1335] Q. Do you know whether California is currently piloting and using a risk assessment tool in the CDCR system?

A. I know that they are attempting to use a couple of risk and needs assessment tools.

Q. And Mr. Specter was asking you about the expert panel report, correct?

A. Yes.

Q. And that report was relating to rehabilitative programming, correct?

A. I think it was beyond that. It was really looking at how to reduce recidivism, which really goes into all areas of public safety, quite frankly.

Q. That report did not analyze medical or mental healthcare programming in CDCR institutions, did it?

A. Not that I recall.

Q. And that program did not provide a population number that was necessary to provide constitutionally-adequate medical and mental healthcare, did it?

A. I don't think it used that language, no. It did recommend reducing the prison population to make it operational.

Q. Okay. Are you aware of any study that sets forth the appropriate population or necessary population to provide constitutionally-adequate medical and mental healthcare in California's prisons?

A. I don't know that those words were used. I know that the [1336] State itself has looked at what it considers to be appropriate level of population to be operational.

Q. Okay. But are you aware of any study that specifically analyzed the population level necessary in order to obtain appropriate medical and mental healthcare?

A. Well, I'm not aware of a study that just dealt with that. But if you're using the term "operational," it includes providing the services to inmates that include medical and mental healthcare.

Q. I took your deposition twice in this case, correct? A. Yes, that's correct.

Q. Ms. Woodford, you do not believe that the only way to provide constitutionally-adequate medical and mental healthcare in cdcr prisons is to release prisoners, do you?

A. Could you repeat that one more time?

Q. Sure.

Mr. Specter: Paul, can you speak a little louder?

Mr. Mello: Okay.

By Mr. Mello:

Q. Ms. Woodford, you do not believe that the only way to provide constitutionally-adequate medical and mental healthcare in cdcr prisons is to release prisoners, do you?

A. I believe that we can only do that by reducing overcrowding.

Q. Okay. But you do not advocate the immediate release of prisoners, correct?

[1378] Judge Henderson: You may call your next witness.

Ms. Evenson: Thank you, Your Honor. Rebekah Evenson for plaintiffs.

Plaintiffs call Dr. James Austin –

James Austin, Ph.D.

Having been called as a witness by the government was first duly sworn and examined as follows:

The clerk: State and spell your full name.

The Witness: My name is James Austin. Last name is spelled A-U-S-T-I-N.

Ms. Evenson: Dr. Austin, as we just indicated, filed four separate expert reports, and we provided courtesy copies of those reports to the court. I won't provide another set of copies now, but for the court's convenience I have reproduced copies of key graphs that appear in his reports.

I also have a correction to one report. Table 8 in the August 15, 2008 report had an arithmetical error which we have corrected. I have revised versions of table 8, which we marked as plaintiff's exhibit number 829.

Dr. Austin's qualifications are set forth in paragraphs one through twelve of his first report which was submitted in November of 2007. So I'm not going to spend too much time on that here.

I'd like to turn now to Dr. Austin.

[1379] Direct examination by Ms. Evenson

By Ms. Evenson

Q Good morning.

A Good morning.

Q Can you briefly describe your educational and employment history?

A briefly, I have a bachelor's, master's degree and Ph.D. in sociology. Got my Ph.D. from the University of California at Davis.

I first started working in corrections in 1970 where I took a job working for the Illinois Department of Corrections and then moved to California and took a job with the National Council on Crime and Delinquency. I worked there for approximately 20 years and then assumed the position at George Washington University for approximately three or four years, and then started my own not for profit institute which is called the JFA Institute, which I presently am the president of.

Q Now, in the course of your work with the JFA Institute, have you had the opportunity to work with state and local governments seeking to reduce their prison or jail populations?

A Yes, I have.

Q Can you describe that work?

A Briefly, I'm presently working in approximately ten states. That would include, very briefly, Michigan, Ohio, Maryland, Louisiana, Mississippi, Kentucky, some more I can name. [1380] Basically, I'm working with those states' state legislators to craft policies that they can develop and implement to either reduce their prison population or stop it from growing. A lot of that work is done through the council state governments, which gets financial grants. Then they subcontract with me to come in and do the analysis for the states.

Q Who are you working within those various states, what actors?

A The principal people I interact with would be governors, staff, legislators, and Department of Corrections officials.

Q And in addition to the ten states you just named, or referenced, have you worked with other states in the past to do the same type of work?

A Yes. In my career I've probably worked with probably 30 some states in this area.

Q In the area of pop–of addressing population?

A It's population reduction, and it is also just analyzing the prison population. A lot of our work is doing population projections, we do that for 20 states now, where we forecast for them where their prison population is going so they can budget appropriately. That also tells them which options they have which can change that population trend.

Q Now, has the U.S. Department of Justice recently asked you to conduct a similar analysis?

A Recently, yes, the U.S. Department of Justice through its [1381] National Institute of Corrections has asked me to draft a white paper for them on how the nation and states could reduce its prison population by as much as 50 percent over the next eight years.

Q In addition to the work you just described, California chose you to be a member of its expert panel, along with other experts and heads of other correctional institutions; is that right?

A That's correct.

Q And the number one recommendation that came out of this expert panel was to reduce overcrowding. Do you agree with that recommendation?

A I do agree with that recommendation.

Q I want to turn your attention to what's been marked as exhibit 830, which is on the easel here. I have additional courtesy copies. Can you briefly explain what this chart shows?

A Yes. I'm going to step over to it and kind of point to some things.

Judge Karlton: You are going to need a microphone. Do we have a–Rowena?

Ms. Evenson: Can we move this and see if this works?

The Witness: Can you hear me?

Judge Henderson: Yes.

The Witness: this is an important chart because when I'm asked to come into a state and look at their prison

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[1404] in relatively low episodic criminal activity. There's a small group, they think, that's very active in their criminal activity. That's the group you want to incapacitate as long as you can. If you can identify them and keep them locked up, yes, you have a positive impact.

But the other group, which is the majority, are just kind of randomly involved in these low level kinds of activities, they are not being affected—they are not affecting us in terms of probabilities of committing crimes against us. They have the same probabilities whether you keep them in six months, twelve months, eighteen months, but you have a huge impact on the prison population and the cost of that prison system. You move that prison population down

30 days any direction, you are talking tens of millions of dollars. That's what you are talking about.

Q Now, Dr. Austin, your models in your report look at arrest rates, but chief dyer, who submitted a report for the Intervenors in this case, assumes that for every arrest, a parolee would have already committed 12 crimes for which they are not arrested. You just alluded to the portion of population that's a career criminal. Can you explain whether you agree with Dr. Dyer's conclusions?

Judge Karlton: Chief Dyer.

Ms. Evenson: Chief Dyer, thank you.

The Witness: I read Chief Dyer's—I have to [1405] Congratulate chief because his city and county has one of the largest drops in crime rates in California, just an extremely large drop in crime. Even though they are getting more parolees each year, he has been able to do that. So I congratulate him on that.

But, basically, what's going on there is—let me put it this way: he mentions the 12 crimes for every arrest. Now, he doesn't cite any studies, so I have to speculate what study he's talking about, but I think he's talking about a study done by Al Bloomstein in the District of Columbia 30 years ago, where Mr. Bloomstein identified people that he calls persisters. These are people that are career criminals. He found of the people being arrested, this is a very, very small percent of the population that's being arrested.

So my number one response to Chief Dyer is that you cannot apply the 12-tt-1 to every person coming out. That would only pertain to these career criminals who are very active and represent a very small portion of the population as being released from prison to his county. So that produces a statistic that just exaggerates the potential danger.

By Ms. Evenson

Q Now, you mention that approximately ten percent—or I don't know if you put a percent to it, but a small percentage of them are actually—of the arrests are actually career criminals?

[1406] A That's correct, a small percentage.

Q And in conjunction with the diversion programs or reduction in length of stay that you have set forth, is it possible to use a risk assessment instrument that would identify those individuals and cull them out?

A Yes, and they should be—they should be using risk assessment instruments. California is a little bit hamstrung because it has determinate sentencing, and that reduces your ability to discretionarily release people.

But even if you have to release people, you can apply a risk assessment that would then tell the police officials, we are releasing John Doe, and he is a high risk person, we need to watch him.

I'll give you an example of a state that's doing that very successfully that I'm working with, which is Maryland. Maryland does that risk assessment, because we discovered in Baltimore City a large proportion of the homicides and attempted homicides, either as a victim or perpetrator, were people on probation, not parolees, but probationers.

So we equipped the probation department with a risk assessment tool, and they are aggressively supervising those people. Aggressive means five contacts a week and zero tolerance. So if they get off —any kind of indication they, are not in compliance, they are brought back into custody. Since we have been doing that, the homicide rate has dropped [1407] about 30 percent in Baltimore City.

So this is an example of not restricting releases to everyone, because also the parole board is paroling more people in Maryland, because they have to reduce their prison population. So they are releasing more people, but those they're releasing or supervising, they're targeting them using risk assessment.

So if you do this properly, you can accomplish all our objectives which is lower your cost, lower the population, make it a safer place for people to live.

Q Dr. Austin, some of the parties in this litigation have given the opinion that local resources for providing rehabilitative programs, like drug treatment or mental health treatment, are overtaxed. Don't those programs need to be in place before you can implement any of these population reducing methods?

A No, they don't. What this will do, this would, basically—again, going back to the original flow diagram, which is producing—this is what we're doing now in California, which has this high recidivism rate, we can talk about that if you want—this will lower the prison population at a level that it will generate, the expert panel estimated and I'm estimating, approximately a billion dollars in savings a year.

My proposal would be to take a chunk of that money and give that to the counties so that they can make this release

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[1429] and Coleman requirements in that report, did you?

A. I'm sorry. Can you repeat that? I apologize.

Q. In your August 15, 2008 report, and your two later reports

A. Oh, 2008.

Q. —In 2008, you did not offer an opinion on whether a reduction of the prison population is the only remedy that will fulfill the Plata and Coleman requirements, did you?

A. That's correct.

Q. You do not know the status of medical or mental healthcare delivery in California's prisons any time in 2008, do you?

A. I believe that's correct, yes.

Q. Its not your opinion that no matter what resources he has or what actions he takes the receiver cannot provide constitutional levels of medical care at current population levels, is it?

A. Well, my opinion in reading the various reports is that they are trying very hard, and they are being unable to reach those levels of care, simply by throwing as much staff and resources they can into the existing system.

It is my opinion that the only way to really solve the problem is to reduce that population at some level. It has to be reduced for the reasons I've stated already.

Q. Okay. I'm going to look at your first deposition of September 19, 2008, page 26, line 22 -- page 126.

[1430] Reading:

> "Is it your opinion that no matter what Resources he has or what actions he takes, the receiver cannot provide for constitutional levels of medical care at current population levels?
>
> "Answer: No."

A. Right.

Q. You wrote in your August 15, 2008 report on page eight, paragraph 19—

Ms. Johnson: August 15, 2008.

This is not the right page. Page eight, paragraph 19.

Up.

That's the wrong one.

Hold on a second. Was that it?

Oh, yes. There we go. The last sentence in the first —take the last sentence of the paragraph, actually.

> "And as will be shown below, comma, moderately lowering the prison population and incarceration rate while using evidence-based models for rehabilitation does not result in higher crime."

By Ms. Johnson:

Q. Do you see that?

A. Yes.

Q. One of the states that you use as an example of the impact of a reduction in the prison population on the crime rate is New

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[Pages 1542-1664] VOL 8

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/08/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Friday, December 5, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Official Official Court Reporters, U.S. District Court

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[1546] early, I hope.

Judge Reinhardt: Thank you.

Judge Henderson: You may proceed.

Judge Karlton: You are still under oath.

The Witness: Yes.

Jeffrey Beard

Having been called as a witness by the plaintiffs was previously duly sworn and examined as follows:

Direct examination by Mr. Specter.

By Mr. Specter

Q. Dr. Beard, you're still the Secretary of the Pennsylvania Department of Corrections?

A Yes, I am.

Q. And I think you alluded last time you were here briefly to the fact that the Pennsylvania prison system was somewhat overcrowded; is that right?

A Yes, we are currently somewhat overcrowded.

Q. At what percentage of operable capacity are you?

A We are at 113 or -14 percent of operable capacity, maybe 115 percent right now, which is about 6,500 inmates more than we would like to have in our system.

Q. And—

Judge Reinhardt: What does that translate into in design capacity?

The Witness: That's very difficult to do, Your

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[1583] Q. And California—

A Right about at the top of that rate.

Q. Secretary Beard, you never evaluated whether California can provide adequate medical and mental health care without a reduction in the prison population, did you?

A No, I never went and visited all—I only visited one institution as I testified to.

Q. You never evaluated whether California can provide adequate medical and mental healthcare absent a reduction in its population, correct?

Judge Karlton: That's what you just asked.

Mr. Mello: Oh, really? It's been a long week. I apologize.

Judge Reinhardt: I'm not sure he answered.

The Witness: My answer would be I haven't personally evaluated it, but I reviewed a lot of information, and I think we talked about this in my testimony before the last time, that I reviewed a lot of reports by a lot of experts, and that's what I do in my job now to run my system. So from reviewing those reports, I would conclude that overcrowding is the prime cause for the mental health and medical problems, and the only way to really address that is to lower the population.

Mr. Mello: I didn't mean to go back to phase one, so I apologize.

Judge Reinhardt: it's not phase one. Phase two is

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[1607] Mr. Galvan: Thank you. Plaintiffs call James Gilligan, M.D.

James Gilligan

Having been called as a witness by the plaintiffs was first duly sworn and examined as follows:

The Clerk: Please have a seat and state and spell your full name for the record.

The Witness: My name is James Gilligan, spelled G-I-L-L-I-G-A-N.

Mr. Galvan: Your Honor, Dr. Gilligan's qualifications are set forth in his report, which is Coleman Document Number 3170, which we offer into evidence at this time. We also offer his rebuttal report, which is Coleman Document 3172.

If I may quickly lay the foundation for his expertise?

Dr. Gilligan is a board certified psychiatrist and professor at New York University. He has 40 years of experience in mental health treatment in prison, jails, mental hospitals, civil mental hospitals, court clinics, and community mental health, and his experience in establishing and running the Massachusetts Prison Mental Health Services under federal court supervision and serving as medical director of the mental health in Massachusetts. His scientific research focuses on the causes and prevention of violence, including in California and [1608] internationally. He has been qualified as an expert in numerous proceedings regarding correctional mental health and forensic psychiatry.

At this time, the plaintiffs ask the court find that Dr. Gilligan is an expert in prison psychiatry and the provision of mental healthcare in prisons, the causes and prevention of violence and the relationship between mental illness and violence.

Judge Henderson: We find he is so qualified.

Direct examination by Mr. Galvan

By Mr. Galvan

Q Dr. Gilligan, you were asked to form an opinion about the impact on public safety of a prison population reduction that could include prisoners with mental illness. What did you conclude?

A Concluded that including mentally ill prisoners in that group would pose no increased risk to public safety. This is based on research done throughout the United States and other countries, as well as specifically in California. There are many studies about recidivism among mentally ill and non-mentally ill parolees, and the consensus from these studies consistently is that the mentally ill are either no more likely to commit violent crimes after discharge, or are significantly less likely to commit violent acts when they return to the community, as compared with non-mentally ill parolees.

[1609] Q When you use the word "recidivism," how do you use that word? What do you mean by that?

A "Recidivism" is a term that could refer to a huge variety of different outcomes. I think a distinction needs to be made between a revocation of parole for, quote, technical violations of parole conditions, such as a mentally ill parolee missing an appointment with a psychiatrist, as compared with revocation of parole because the parolee has committed a new crime, either a violent crime or property crime or whatever. So it's a term that's ambiguous and is often, I think, misused as if it always referred to the same thing.

One distinction between the mentally ill parolees and the non-mentally ill in California specifically, is that the mentally ill parolees are significantly—that's statistically significantly less likely to return to prison because of a new offense, that is of committing an act that could be regarded as a crime or prosecuted as a crime, as compared the non-mentally ill parolees. When they do commit a crime, they are no more likely than the non-mentally ill to commit a violent crime.

Q In the material you looked at regarding California mentally ill parolees, were there particular types of reasons they tended to return to prison?

A Yes. The mentally ill parolees were significantly more likely than those non-mentally ill to be returned for purely technical violations, rather than behavior that, under other [1610] conditions, would be in any way considered criminal.

Q Are there any examples of technical violations which are particularly susceptible?

A I'm sorry. Could you repeat?

Q Are there any examples of technical violations to which parolees with mental illness are particularly susceptible or more likely to commit?

A Yes. When I mentioned just simply missing an appointment or in some other way not complying with treatment, which is—by the way, that's a condition which has been repeatedly described by officials within the parole department in California as very frequently a product of the mental illness itself, that is, the mentally ill parolee is too disorganized or too paranoid, whatever it might be, to participate in the treatment, you know, exactly as required.

Q Were you also asked to look at the links between mental illness and valid predicters of future violence?

A Yes. As I said, within the parole population, the mentally ill are no more likely than the non-mentally ill to commit future violence. There's actually some evidence that the more severely mentally ill parolees are actually less likely than the non-mentally ill, they're just too disorganized or socially withdrawn.

The more important point, though, I think in response to your question, is that the predicters of future violence, [1611] that is, the risk factors that predict violence in the future, are the same both for the mentally ill and non-mentally ill parolees.

For example, future risk factors that predict violence are age, sex, substance abuse, access to weapons, prior criminal history, certain kinds of personality disorders, which are not Axis I mental disorders, and I would say the general category of socioeconomic hardship, poverty, homelessness, things of that sort.

Q You were also asked for an opinion about how California could improve upon the status quo regarding public safety and the current flow of mentally ill parolees from the prison system. What did you conclude with regard to that?

A That one of the most important things the State of California could do would be to reduce the churning of parolees and disproportionately, that means mentally ill ones, from the community and into the prison and back again, sort of short periods in each place, which disrupts every kind of reintegration into the therapeutic or rehabilitative activity and so on.

The main things I'd emphasize, though, in terms of practices that would improve public safety would be to make sure that every parolee leaving the prison, there was a significant prerelease planning, starting, hopefully, months before they leave; secondly, assuring they have access to care when they [1612] return to the community; thirdly, making sure they had access to treatment for dual diagnosis problems, that is, people who are both mentally ill and have substance abuse problems, to make sure they can actually get that treatment, and, fourthly, to increase, I'd say, coordination with community mental health providers to get them involved in the treatment process with a returned parolee.

Q. You referred earlier to statements of California officials regarding the churning phenomenon. Were there any particular statements from high level officials?

A Absolutely. I could mention the—well, Mr. Kernan's comments that we have on video.

Q. What were—

A And Mr. Tilton.

Q. When you mention Mr. Tilton's comments, we can play that for the court. If you look—or you can tell me, also. What is the significance, before we do that, of what you saw from Mr. Tilton?

A Well, the significance is that the mentally ill who are in prison are, in many cases, there simply because access to mental health has not been made—mental healthcare has not been made available in the community. In other words, the prisons in California, as in many other states, have a significant number of prisoners who are in prison primarily because they are mentally ill and they can't get treatment elsewhere. So the [1613] prisons are being treated as the de facto mental hospital system.

Q. I'd like to show you that statement and ask you if it's the one you were referring to. Could we look at, roll, plaintiff's exhibit 361, 361? Plaintiff's exhibit 361? It will need sound.

(Video played.)

By Mr. Galvan

Q. Is that the video you were referring to?

A Yes.

Q. You mentioned a statement by Scott Kernan, Mr. Kernan. I'd like to show you that and ask you if that's the one you are referring to. That is P 360.

We can come back to that. I'm going to move forward to one of the other things that you were asked to opine about.

You were also asked to write a—I'm sorry—you were also asked to write a second report, a rebuttal report, regarding the impacts of a population reduction on community mental health services in California. How did you go about forming your opinions in that area?

A Well, first of all, I reviewed the actual classification of prisoners as to their mental health status and the numbers involved, and it appeared to me that it would be very easy to exaggerate the impact of discharging mentally ill prisoners on the county and mental health system if the one doesn't actually look at the relatively small numbers involved.

[1614] Could we look at Figure One, which shows the number of parolees discharged in recent year, 2006, I believe?

(Document displayed.)

The Witness: what that shows is that in 2006 there were roughly 135,000 releases to parole, of which about 20 percent, or roughly 27,000, were of people who had been classified in need of mental health services within the CDCR. Of those, the vast majority, almost 24,000, were at the lowest level of mental illness of a 3CMS group, which is classified as really not needing any inpatient treatment, or even particularly intensive outpatient treatment. These are people that could easily be handled in a community mental health system with appointments, you know, from every one to three months, maybe one appointment. Many of them won't even need continuing treatment.

The next more severely disturbed are the EOP, or enhanced outpatient population, which is about 2,400 of this group. But these are also classified as people who do not need inpatient treatment. They don't need mental hospitalization. They specifically are people who are manageable on an outpatient basis. So these are people that might be patients in a community mental health clinic.

There's a much smaller number of that, a little over 600, who need either a crisis bed or a DMH hospitalization. That's of the entire 135,000 who were discharged under the [1615] status quo in 2006.

If we looked at a specific—if we could look at figure two, we could see what this would amount to if we were talking about, say a release of 30,000 people into parole to just to decrease the prison population by that much.

What you can see is that the number of people who would need inpatient treatment in this group, the crisis bed and DMH, at the top would be about 143 people, and only a little over 500 would need even regular outpatient treatment of the EOP group.

Now, I would mention that the county mental health system in California as it is now operating has approximately 658,000 patients. That's 658,000. Of those over 43,000 need 24-hour-a-day care. So what were talking about is adding to that population of 24,000 maybe 140 who would need outpatient care, and of the 658,000, were talking about, maybe 6,000 that would be, you know, an increased population, again, the vast majority of whom would need only minimal mental health care.

So I emphasize that because I think it's important not to exaggerate the impact or the stress the difficulty that the county and state mental health systems would have if these mentally ill parolees were actually being taken care of by the mental health system rather than being placed in prison, which are, of course, the worst possible location for someone who's mentally ill.

[1616] Q. In doing in the analysis, did you conduct a county-by-county review?

A No, I looked just at the state—state figures as a whole.

Q. Are you saying that, in your opinion, the California community mental health system has all the funding that it needs?

A No. I mean, I don't pretend to be an expert on that subject, but from what I have been told, what I've read, I continually hear that the county mental health system is underfunded and understaffed, according at least to the judgment of the people who work in that system.

Q. And in looking at the statements in the defense expert reports on community mental health, did you form any opinions about their discussion of the resource problems?

A The representatives from the county mental health system.

Q. I'm thinking particularly of the defense experts.

A Yes.

Q. Ms. Bataille and the county experts?

A They were making the point repeatedly that they felt the counties' mental health system, since it is underfunded, could not afford to treat more patients. What I would—what I think is worth noticing, though, is that actually what the state of California is doing now with this population of mentally ill parolees is vastly more expensive than taking care of them within the mental health system would be.

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[1642] with the release of 15,000 or 50,000 inmates?

A Well, I mean, any time an inmate is released, there's a risk of recidivism, sure.

Q. Would you also agree there's a risk that a released offender may commit an act of bodily harm on another person while on parole?

A There is also that risk.

Mr. Lewis: Thank you, Dr. Gilligan.

I have no further questions, Your Honors.

Judge Henderson: thank you, counsel.

Anything from Intervenors?

Ms. Fuentes: Good morning, I'm Theresa Fuentes from Santa Clara County on behalf of defendant Intervenors.

Cross-examination by Ms. Fuentes

By Ms. Fuentes

Q. Dr. Gilligan, do you agree that mentally ill prisoners who will be released or diverted from prison under a population reduction will need access to some sort of mental health treatment in the community?

A I would think so, and I would certainly recommend it.

Q. That would be whether they're 3CMS or EOP; it would just depend on the level of treatment that they need?

A Yes. The important thing I want to emphasize is simply how highly variable that is, as I was trying to say, from the most intensive to the least intensive.

[1643] Q I think you said, in your opinion, the 3CMS would need maybe some appointments with mental health professionals and access to medications?

A I would assume that most or all of them would need that at some point, but I would also not be surprised if many of them did not need it on–on an ongoing basis.

Q But you don't have any idea what the actual numbers would be of who would need medications in the community?

A I don't think anybody could predict that in advance. I just think the appropriate thing the mental health system could do is to respond to whatever the need would turn out to be.

Q It would depend on what their needs are out in the community?

A These could vary from one time to another even within the same person, of course.

Q And do you agree that the mentally ill released prisoners would need some sort of housing, access to housing?

A I would–well, I would certainly recommend it. I don't recommend homelessness for anybody.

Q And some sort of support structure as part of their treatment regimen?

A Again, the need for this would vary enormously. I think all inmates leaving prisons, whether they're mentally ill or not, really, they benefit, and public safety benefits from their having a lot of help in getting reintegrated into the community [1644] with adequate housing, employment, or at least income a base, and so forth.

Q Okay. And do you agree that California counties do not currently have funds or resources to provide any of those type of services to prisoners who would be diverted or released under a population reduction?

A I don't know how this relates to their resources. My understanding, though, is that they, the parolees, are simply excluded from access to the county mental health systems. That's why the parole officers often have to send them back to prison.

Q So they are not receiving treatment in the community, is that what you're saying?

A That's my understanding.

Q So what about mentally ill individuals who are diverted or are not able to be sent to prison because of a population cap, what about those?

A Well, if the county mental health system would then agree to provide them treatment, I would think that would be the appropriate response.

Q What if the counties don't have any funds or resources to provide the treatment?

A Well, I would say that would create a situation that the citizens of California would have to deal with. I mean, that's why California has a government and a legislature and an [1645] executive branch and so on. That's what they exist for.

Q Well, do you agree it would impact public safety if there were mentally ill individuals, offenders who were unable to access any sort of mental health treatment in the community?

A Well, I think it–there would be an adverse effect on

public safety if any released prison inmate did not have access to the services they needed in the community. That would include the mentally ill and the non-mentally ill, all of whom need one kind of service or another.

But what I'm trying to get at is right now the resources of the state–and, obviously, they're always finite, they're limited resources–are disproportionately put at the service of the prison system, in part because the prison system is taking care of people that the mental health system 50 years ago would have taken care of directly.

If we are going to–if the prison population is going to decrease and a certain number of mentally ill people will be in the community, this might be an historical time for the state and other states in this country to think of redistributing resources from the prison system back into the mental health system.

Judge Reinhardt: Doctor, are you saying it's more dangerous for the safety of the community to continue the prison system the way it is than to release these people with adequate treatment?

[1646] The Witness: Absolutely. I really think–I think the status quo is more dangerous than releasing people, assuming that, you know, the citizens of this state and the mental health professionals and so on are willing to respond to this, you know, in ways that are appropriate and necessary. Again, I've indicated from the figures that I projected onto the screen what a relatively small number of people we're talking about in a mental health system that is already taking care of at least 658,000 patients.

Judge Karlton: Let me follow up from Judge Reinhardt's question. What we're doing now, in your view, is dangerous for public safety, in your view?

The Witness: Yes, that's what I'm talking about.

Judge Karlton: And your view, as I understand it, is even a release of as many as 50,000 people, given the relatively small number of mental health people who would be released just if you just follow the average, will not have a substantial increase in the danger to the public which exists today?

The Witness: Yes, Your Honor.

Judge Karlton: but that if the state were to divert funds from the prisons to the community, among other reasons because they would not need as much funds for mental health in the community in the prisons, that would, in your view, have a substantial beneficial–I don't know substantial–a beneficial effect on public safety?

[1647] The Witness: Yes.

Judge Karlton: Is there any way for you to

quantify–and the answer may be no, I understand that. Is there any way for you to quantify the benefit in terms of cost?

The Witness: Yes, I mean, I could at least refer to some figures that I think would be relevant in making such an assessment. I also mentioned a crude estimate of the cost to the state for each prisoner in the prison system is costing roughly $43,000 per year. That may actually be an underestimate.

The figures that I've heard with respect to really full scale inpatient mental hospital treatment are more on the order of $30,000. And for outpatient treatment I've heard figures–again, I'm talking about in California–are figures of averages of maybe $4,500 a year, which is roughly one-tenth as much as it cost to keep somebody in prison.

So what I'm saying is I'm very aware and very sensitive to the fact that any state's resources financially are limited. They're finite. What I'm trying to say is I think the kind of change that we're talking about here, not only would be better for the mentally ill, would not only be, I think, an improvement in public safety, it would actually save the taxpayers money.

By Ms. Fuentes

Q Well, do you agree there's no guarantee that the counties [1648] will receive the funding to provide those services?

A I understand that. That's always the risk in a democracy.

Q So the result may very well be that there are just more untreated offenders in the community?

A If the state decided that's what the state wanted, that's what the state would get.

Ms. Fuentes: Thank you.

Judge Henderson: Redirect.

Redirect Examination by Mr. Galvan

By Mr. Galvan

Q On cross there was a lot of discussion of risk in various ways. Are mentally ill offenders more risky than other offenders when they're released?

A No.

Q Why not?

A The likeliest explanation is that people suffering from the severe mental disorders, the Axis I disorders, which is what we're primarily talking about here, are more likely to be socially withdrawn than they are to be socially aggressive. They're more likely to be disorganized than they are to be capable of carrying out a–you know, a complex crime, you know, like robbing a bank or whatever, and I mean, even people who are very paranoid are more likely to respond with fear and withdrawal than they are with attack.

So I think it's–I realize it's somewhat

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[Pages 1665-1887] VOL 9

UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND FOR THE NORTHERN DISTRICT OF
CALIFORNIA UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES PURSUANT TO
SECTION 2284, TITLE 28 UNITED STATES CODE
[Filed: 12/10/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Tuesday, December 9, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. PAS, CSR 11916, CRR, RMR, RPR
Official Official Court Reporters, U.S. District Court

* * * *

[1669] Direct examination by Mr. Mello

By Mr. Mello

Q Good morning, Secretary Cate.

A Good morning.

Q When were you appointed as the Secretary of the California Department of Corrections and Rehabilitation?

A May 16th of this year.

Q Okay. Immediately prior to that point, what position did you hold?

A I was the Inspector General for the State of California.

Q And can you generally describe what your responsibilities were in that position?

A I was–as Inspector General, I was responsible for the oversight of the Department of Corrections and Rehabilitation, including auditing its systems, investigating misconduct by senior personnel, and overseeing the officer discipline process.

Q And you served on the California Rehabilitation oversight board, also referred to as CROB, from 2007 until your appointment, correct?

A I'm actually still a member of the Rehabilitation Oversight Board. I served as its chair in my capacity as the Inspector General, and I'm currently a member of the board in my capacity as secretary.

Q What were your responsibilities as chairman of CROB?

A I lead the board, and its responsibilities were to oversee

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[1680] reentry beds. That process is going on through–I think It's six different–excuse me–12 different communities at this time. So I think those are the primary efforts.

Q And are your–are CDCR's efforts to reduce its inmate population driven by the effort to reach a particular population number?

A No. We're trying to use the best correctional practice and science to reduce our population safely, but there's no particular number that we're trying to reach. I mean, I think that the Administration's goal and my goal is to get rid of what we call non-traditional beds or bad beds, meaning beds in gyms or beds in dayrooms. They make our business more difficult.

Q Have you been successful in eliminating some of those non-traditional beds?

A Largely through our out-of-state program, we have been able to reduce our number from approximately 20,000 to just under 14,000 now.

Q And are you familiar with the January budget proposal which again happened before you were even Secretary with respect to CDCR?

A Yes.

Q And what was that budget proposal, to your understanding?

A As it related to CDCR, there was–well, the Governor proposed a ten percent across-the-board cut to deal with the budget problems in California, and the solution from CDCR at [1681] that time was the release of 22,000 non-serious, nonviolent inmates before their terms expired.

Q Was that budget proposal adopted?

A No, it was taken out in what's known as the May revision to the budget.

Q Mr. Secretary, to your knowledge, has the projected budget deficit for the State of California increased since January 2008?

A It has.

Q And did the Governor recently convene a special session of the Legislature to address this increased budget deficit or projected deficit?

A He convened a special session of the last Legislature which ended November 30th, and there's been talk of another special session. I'm not sure if it's been officially convened, though.

Q Okay. Are you familiar that there was a budget proposal–strike that.

What was the focus of that last session, to your knowledge, economically?

A Well, the focus was to cut the budget or raise revenue, do something to balance California's fiscal situation, and, I mean, so all departments took part.

Q Okay. Is it your understanding that the projected deficit for '07/'08, '08/'09 and '09/'10 is bigger than even anticipated?

* * * *

[1683] releases, correct?

A Correct.

Q And in April of 2006, you put out a press release about an audit that you had done; is that correct?

A I'm sure it is. I don't know which one you are referring to.

Q It's the audit you did of all the other audits to determine what percentage of recommendations the cdcr had complied with; do you recall that?

A Yes, we called it the accountability audit.

Q Right. In that press release you said:

> "Severely hampering the Department's ability to address its problem, the Inspector General noted, is an inmate population that has prisons straining at almost double the design capacity." Do you recall that?

A Yes.

Q And that statement is true now as well, isn't it?

A It is. Overpopulation makes everything we do more difficult.

Q And you also said in that same press release:

> "As the inmate population increases, Controlling violence, offering education, delivering health-care, managing overcrowding, and controlling costs become more difficult."

[1684] Do you recall saying that?

A Yes.

Q That's true now as well, correct?

A It is.

Q And it's your position that overcrowding needs to be reduced because it makes everything easier to do in a prison, correct?

A Yes.

Q And because it makes everything easier, it will have an impact on the Receiver's ability to provide healthcare to prisoners, correct?

A I think it will be. Obviously, that's fewer doctors that need to be recruited, for example, and less clinical space that would have to be built, less money that would need to be spent On those examinations, et cetera.

Q So the answer to my question is yes?

A Yes.

Q Okay. Now, you believe your charge as Secretary is to ensure that any strategy the CDCR employs to reduce the prison population does not cause more victimization in society; is that accurate?

A That's one of them, yes.

Q And you believe that the measure that you use in evaluating whether CDCR's strategies are safe is their effect on the overall crime rate, true?

A I think that's probably part of the calculus.

* * * *

[1694] here, it says "this pilot program"?

A Correct.

Q Could you read that first sentence, please?

A "This pilot program will remain in effect for a 24-month period from November 3, 2008 through November 3, 2010, at which time it will lapse by operation of law or will be promulgated through the Administrative Procedure Act."

Q Thank you.

A But I think that's just a matter of semantics. The point is that we're going to be rolling out the entire thing at 90 days and then studying it and making changes along the way during the course of the two-year period.

Q Okay. As of the end of August, which is when the court has held that we stop talking about the conditions, there was about 4,788 out-of-state transfer beds–people in out-of-state beds, correct?

A That's right.

Q Now, in the Governor's special session for the November 2008 Legislative special session, he recommended various prison population reducing measures, correct?

A Correct.

Q And those–did you recommend that he make those proposals?

A I definitely was consulted and took part in that decision-making process. I brought some of those ideas forward.

[1695] Some were ideas that other stakeholders had brought forward that we adopted. Some were ideas that had been bandied around before.

Q Did you believe that–did you tell the governor that any of those proposals shouldn't be put forward because you didn't believe they were safe for the community?

A I'm sorry. Can you remind me which proposals we're talking about again?

Q The November 2008 budget proposals.

A Okay.

Judge Karlton: Did you recommend he not adopt any of them because they adversely affected public safety?

The Witness: No. I recommended, in light of the budget crisis we were in, this was the best we could do.

By Mr. Specter

Q Those recommendations included no parole supervision for offenders without a conviction for a non-serious, nonviolent, or sexual crime, correct?

A And those who had–it was those who were not convicted for non-serious, nonviolent, non-sex, but you also have to have never been convicted of a serious, violent or sex crime in your past.

Q Correct. And it also included up to four months for each program successfully completed by a prisoner, correct?

A Correct.

[1696] Q And so if a prisoner completed four programs, he could get a year off of his sentence under that scheme if it was enacted, correct?

A Well, the details of whether there would be a cap on the amount of credits you could earn were to be determined at a later date, but you could earn up to three months credit for as you described.

Q Four months, I think.

A Or four months, right.

Q It would also provide that prisoners would get day-for-day credit, those who were eligible for it, for obeying the prison rules, correct?

A Correct.

Q This would result in earlier release of some prisoners, right?

A No. It would result in them serving less time, but they would serve the time prescribed by law.

Q They would get out of prison less–they would get out of prison earlier, wouldn't they?

A Earlier than they would have been, yes.

Q Okay. And you also–the Governor also proposed day-for-day credit for prisoners who are in jail awaiting their transfer to state prison, correct?

A Correct.

Q And this would result in prisoners getting out of prison [1697] earlier than they otherwise would have, right?

A That's right.

Q And it also would have provided additional credit for prisoners who are waiting for an assignment to a conservation camp, correct?

A Correct.

Q And this would result in earlier release of some prisoners, correct?

A Earlier release, yes.

Q And how many credits–what's the ratio of credits that prisoners in conservation camps get now?

A Two for one.

Q So this would give them possibly–those who are waiting to get into conservation camps, was your intent to give those prisoners two-for-one credits?

A Yes.

Q So they would get two-for-one credits even though they weren't working in the camp; is that right?

A Because they are in the process of being trained and going to the camps, yes.

Q And you also–or, I'm sorry, the Governor also proposed increasing the statutory monetary threshold for determining whether property crimes could be prosecuted as grand theft, correct?

A Correct.

[1698] Q That's because the statutory limit hasn't been raised somewhere in the 20 years, correct?

A I'm not sure of the number of years, but for many years, yes.

Q It hasn't caught up with inflation, in other words, right?

A That's right.

Q And this would result in less offenders coming to state prison; isn't that right?

A It would.

Q And the November special session ended without any Legislative action on these proposals; isn't that correct?

A That's right.

Q Now, before the special session, you mentioned, when you were on direct examination when you were asked, that there was a May revision to the Governor's budget in 2008, correct?

A Correct.

Q And you were consulting the governor about that may revision when it was announced, correct, or before it was announced, correct?

A Yes.

Q And that included –

A Yeah. I was going to say not as the Secretary, but I did in my role as the Inspector General, I did consult, I think, once.

Q And that budget proposal contained a proposal to provide for summary parole, correct?

* * * *

[1734] (Recess taken.)

Judge Henderson: Okay. You may call your next witness, counsel.

Mr. Lewis: Good morning, your Honor. Kyle Lewis for the state defendants.

Defendants now call Thomas Hoffman.

Thomas Hoffman, Called as a witness for the defendant herein, having been first duly sworn, was examined and testified as follows:

The Witness: Yes, I do.

The Clerk: State your full name for the record.

The Witness: Thomas George Hoffman. H O F F M A N.

Direct examination

By Mr. Lewis:

Q. Good morning, Mr. Hoffman.

Mr. Lewis: Your honor, defendants have submitted a trial affidavit for Mr. Hoffman previously identified as exhibit 1005, and I ask the court to take it under submission at this time.

Judge Henderson: it will be done.

By Mr. Lewis:

Q. Mr. Hoffman, are you currently employed by the State of California?

A. Yes, sir.

[1735] Q. What department do you work for?

A. California Department of Corrections and Rehabilitation.

Q. What is your current position with CDCR?

A. I'm the Director of the Division of Adult Parole Operations.

Q. Please inform the court of your prior work before assuming the role as Director of Parole Operations?

A. From 1975 to 1994 I worked for the city of Inglewood police department. I went from officer to captain there.

I left Inglewood p.a. In April of 1994 to join the west Sacramento P.D. As the then captain. Ultimately became the Deputy Chief of Police. I retired in April of 2004 as an interim chief of police.

Q. And how long have you held the position as director of the Department–or the Division of Parole Operations?

A. Twenty-eight months.

Q. How many parolees are currently under the supervision of the Division of Parole Operations?

A. About 125,000.

Q. And are these parolees broken down into different classifications or service classifications?

A. They are broken–yes, they are broken down into groups based on their needs. Mental illnesses is a group. There's sexual offenders that we supervise specifically, gangsters, second strikers. You know, I'll say the generic population. All of them are organized in a way that revolves around first

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[[1741] and needs of that individual; be it education, drug, anger management, social skills, education.

And this rather extensive document is included in the pre-parole plan package that goes to the parole agent and his supervisor prior to the inmate being released and on parole. It provides us with an opportunity to develop a parole plan that is individual specific and sensitive to the needs and risks of each individual.

Q. Is there a risk that a parolee will reoffend even if they use this tool, even if you use this tool?

A. Oh, absolutely. Yes.

Q. The court has heard testimony from other–that other states use a parole violations tool. Has cdcr implemented a parole violations tool?

A. Yeah. We are really excited about it. We have been working on our parole violation instrument with the center for effective public policy since July of 2007.

We went through a very detailed, involved process to build a tool that's sensitive to the unique environment of California parole.

We now have that tool in a pilot–in a pilot capacity in four units, one in each of our four regions, and we are actively using it now.

And a real good advantage to the tool is we have also embedded the California static risk assessment into the PVDMI [1712] process. So when we are faced with a decision about a response to a violation or commission of a new crime, we are considering the risks that the specific parolee represents to our communities and, also, we are–we have determined the risk of the incident violations.

So it's a two-fold decision-making process that lends itself to guiding the agents towards consistent and proportionate responses to violations.

It's a part of an overarching agenda that says we want to move ourselves towards policy-driven responses to violations of parole and commissions of new crimes so that we can have a consistent and predictable and proportionate response to violations from one end of our state to the next.

Q. Will the PVDMI, or parole violations tool that you are describing, will it help possibly push parolees towards alternative sanctions programs or remedial programs rather than send them back to prison?

A. Yes, because what it does is it guides our agents. As we sit here today, there's about 2400 agents making these decisions this morning. It guides our agents and their supervisors through a very thoughtful structured process so that the full range of alternatives and appropriate responses to violations and commissions of new crimes are considered in each instance.

Q. What kinds of remedial programs are available to parolees?

A. It runs the gamut. There's about 100 million in programs [1743] funded via CDCR in parole. They include such things as the Day Reporting Centers and literacy labs and drug treatment programs and residential Multi-service Centers and care for the mentally ill.

Then we also work very closely–sometimes an uphill battle, but very closely with local communities and private service providers to expand the menu of service that we can offer this large population of parolees.

Q. Have other states demonstrated positive impacts from the use of a parole violations tool?

A. The Center for Effective Public Policy, who are the folks that have helped us build ours, have helped 33 states and/or county parole and probation operations undertake a process, as I said, more commonly referred to as policy-driven responses to violations. One of the outcomes is frequently the development of a decision-making instrument of one kind or another.

States like Texas, New Jersey, Kansas, Ohio, Florida have all engaged in this process and all of them have seen a reduction in the use of the revocation process and in the parole environment, a reduction in prison populations and better outcomes from the parolees.

Q. Do you believe that the use of the California parole tool will eventually result in less recidivism and fewer parole revocations in California?

A. Absolutely, absolutely.

[1744] Q. In your opinion, will the use of a risk and needs assessment and the parole tool result in a different kind of CDCR population after some time?

A. Yes. It will provide us with an opportunity to bring–and this is a huge step forward for our state. We will bring science and evidence-based practices to what has historically been a clinical decision about risk. The research validates that the clinical decision or conclusion about risk, you get it right about 50/50, 50 percent of the time.

When you introduce a validated evidence based tool, you bring that threshold up to about 70 percent. If you also have talented professionals, you can continue to bump that ratio up where the decision can be right in excess of 70 percent of the time, recognizing you are never going to get 100 percent.

The clerk: Time is up, counsel.

Mr. Lewis: If I might ask a few more questions, your Honors?

Judge Reinhardt: Let me ask one before you continue,

Counsel.

In answering the last two questions you used the word "eventually" and then in another instance "after some time."

Is there anything within your own experience or looking at programs from other states that can tell you concretely or semi-concretely when these changes–when you'll start seeing these changes?

[1745] The Witness: Other states, you know, like Kansas and Texas, Illinois see the changes quickly. The caveat for California is, we are the gorilla in the crowd.

Ohio, as an example. Ohio has about 37,000 parolees that they supervise. They have just recently come out with, just in the last week, the most extensive review of the decision-making instrument process ever and it validated that they've experienced significant reductions in revocations and the use of incarceration in this process very quickly.

Judge Karlton: what does "very quickly" mean? A year? Six months? What does it mean? I understand that you don't have a precise number, but rough.

The Witness: You are going to see the change virtually immediately, recognizing that it will take–and this is why–I'm not trying to avoid the question but, you know, when you–when we run through 70,000 or 80,000 violations, the impact of having a structured decision-making instrument and alternative sanctions will be recognized quickly.

I guess one way to answer your question, your Honor, is we are using this tool right now in four of our units. In the first couple of weeks when we–our agents used the tool, they agreed with the tool–and this was about 113 cases. They agreed with the tool all but six times, and then the outcome that that tool recommended.

And I think what you will see–I know what you will [1746] see quickly is consistency and continuity in these responses and a new focus. This is–some of this is cultural, but a new focus on recognizing that what parole is about is helping folks to safely and effectively transition back into society whenever we can make that happen.

Judge Reinhardt: How long will it take before it's in effect state wide?

The Witness: We will have this–the plan is to have the PVDMI state wide before the end of next year.

Our strategy at the moment–and, obviously, all of this is, we could–we could accelerate this, but the plan right now is that beginning in February we will begin to roll this tool out in four districts every 30 to 45 days. There's 25 district in our state system. So we would roll four out every 30 or 45 days. Right now projecting that by October, maybe November–October seems to be a pretty comfortable date for us–that we would have the tool up and our agents trained and everybody using it by then.

Judge Karlton: And the budget crisis and the apparent determination that one way or another every agency is going to have to take a hit will delay that to some degree, and you don't know how much that will be because it depends on how badly you are hit?

The Witness: Your Honor, I don't believe that it will–it will delay the implementation of the use of the

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[1753] handle, sounds like about 2500 more parolees a month coming into our system.

Q. Additional resources in what regard? What would you need; more parole agents, more housing, more what?

A. Yeah, we would need–yes. Our–parole is financed at 70 to 1. Every 70 parolees that come into parole, we get an agent for the–you know, non-specialized case loads.

But, yes, we would need additional agents so that we can maintain case loads where we are. We need more supervisors. I mean, you just run through the whole gamut of personnel and logistics and, of course, adding that number of parolees into the communities each month would further stress an already stressed infrastructure for programming.

Q. Thank you, Mr. Hoffman. No further questions.

The court: Redirect?

Judge Karlton: Cross.

Judge Henderson: I'm sorry, it would be cross. Thank you, Judge.

Mr. Galvan: Ernest Galvan for the plaintiffs.

Cross Examination

By Mr. Galvan: Q. Good morning,

A. Good morning. Mr. Hoffman.

Q. Mr. Hoffman, you were just testifying about the resources you would need if you had more parolees to care of.

[1754] In your trial affidavit you cited that this document, the final report of the U.C.L.A. evaluation of the mental health services continuing program–and if I could zoom on the chart at the top there–and just ask some foundational questions.

(Document Displayed)

The mental health services continuum program is the program that does pre-release appointments and benefits planning for the mentally ill people about to be released from prison; is that right?

A. Yes.

Q. And your Department Commissioned U.C.L.A. to study the effectiveness of that program, is that right?

A. Yes, sir.

Q. And then what we have up is part of one of their reports that they provided to you, is that right? Just a page from one of them.

A. Yes, sir.

Q. Okay. And this is an exhibit number, defendants' 1205. It's one of the exhibits to your affidavit, sir.

And part of their job was to tell you whether or not it was cost effective to invest in all this pre-release planning for the people about to parole, is that right?

And so as part of the basis, they made this chart for you. Estimated daily parole cost on the side there, about $10. Estimated daily incarceration cost for a person at the Enhanced [1755] outpatient level of care at the B.O.P., about $94?

A. Yes, sir.

Q. About ten times more to keep somebody in prison than to take care of them on parole, is that right?

A. In this instance, yes, sir.

Q. You were testifying earlier about the proportion of the violations that you have to refer to the Board of Parole Hearings for formal proceedings under a regulation that you referred to as 2616, Title 15?

A. Yes, sir.

Q. And that's also known as the Robin Regan regulation, is that right?

A. Yes, sir, it is.

Q. And that's one of those laws or regulations that we got in California because there was a high profile murder and someone did a campaign to make that regulation, is that right?

Mr. Lewis: Objection. Lacks foundation.

Judge Karlton: Can you tell us if that was the motivation?

The Witness: That is how it's been characterized to me. I was in law enforcement at the time. I wasn't tracking the discussion, but that's how it's been told to me.

By Mr. Galvan:

Q. So your answer is yes?

A. Yes.

[1756] Q. And that's just a regulation, correct, administrative regulation?

A. Yes, sir.

Q. And your administrative agency can change regulations through a formal process, is that right?

A. We can change a regulation, that's true. This is a regulation by the board or of the board, not of DAPO.

Q. And are you aware that Senator George Runner authored an initiative that was on the ballot this last November, Proposition 6, the so-called Save Neighborhoods Act, that would have made 2616, the Robin Regan regulation a statute?

A. Yes, sir.

Q. And are you aware that the voters turned down that Proposition? They voted it down?

A. Yes, sir.

Q. To your knowledge, California is one of two states, right, that tries to put everybody released from prison on parole?

A. Currently we are the only state. We were in company with the state of Illinois and Illinois has now ratcheted back.

I think as we sit here today, there are about 84 percent of the people that come out of an Illinois institution would go on to what you and I see as formal parole.

Q. And shortly after you were appointed, you went to Illinois to study what they were doing there in parole reform, is that right?

[1757] A. I went there with Dr. Petersilia, yes, sir.

Q. And Dr. Petersilia is Joan Petersilia, the head of the Center for Evidence Based Corrections at U.C. Irvine, is that right?

A. Yes, sir.

Q. And she has been frequently retained by the Department of Corrections as a consultant to study and advise them on their programs?

A. Yes, sir. And I talk to her frequently.

Q. And she assisted you with the development of the parole violations decision-making instrument, is that right?

A. Yes, sir. She is a very close confidante.

Q. And so for the–the status quo in California right now is that every month–every month you get about 10,000 new parolees, is that right?

A. Yes, sir.

Q. And you have to supervise them all for up–for roughly three years for each one, is that right?

A. Well, minimally 13 months. Many of them are on parole for up to, you know, 48 months, yes.

Judge Karlton: excuse me, Mr. Galvan.

We hear a lot about probation having banked cases. Does parole have banked cases?

The Witness: No, your Honor, not at the moment, although there are ongoing discussions about engaging in that [1758] classification.

By Mr. Galvan:

Q. And it's your view that maintaining supervision on the low risk end of that 10,000 group does not do anything to promote public safety, is that right?

A. No, sir. What I would say is that the science and evidence, and there's lots of it all across this nation, does support a conclusion that there is a percentage of the parole population that shouldn't be supervised or supervised very little; that at the low end of the spectrum supervision is counter productive.

Q. Why is supervision counter productive at the low end of the spectrum?

A. I guess the way to describe it, you introduce low end offenders to high risk career criminals and gangster types, the tendency is that the low end folks are more–I will say more motivated–not motivated, but more influenced by them than the reverse. Basically, you poison the pool.

Q. What does front loading parole mean?

A. It's a concept that says–and there's a lots of research behind this as well, and we are very much interested in this; that says if you can get to the parolee quickly, and if you–really, in the first weeks after they are released and get them stabilized, housing, hopefully a job, educational, income, simple things like drivers license, social security cards, and then you do that well in the first 90 days, recidivism rates are

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[1768] A. The average term is about 4.2 months for a revocation and our recidivism rates do run about 70 percent.

Q. And then a person who churns through that for 36 months, or three years–or four years because they get the extra year added on for their violation time, then they discharge from all supervision by operation of law, is that correct?

A. That's the reality at the moment.

Q. And you discharge about 56,000 people a year, is that right?

A. On average about that number, yes, sir.

Q. And it's your view, isn't it, that if you take a person through that history, where they churn through their whole time on parole, they do the whole time in prison, out of prison, that all you are doing is postponing future victimization and crime?

A. That's true. And I would say that, you know, it's important to understand that our culture is in the midst of a huge change. We are part of a system that was about–all through the criminal justice system in California for the almost 34 years I have been part of it is largely punitive. Certainly the CDCR and DAPO side of the equation was largely punitive. And now we are.

It's a fascinating experience to watch rebuilding a rehabilitative side of our obligation, both inside and out of the institutions.

With that comes the struggle that we have at the [1769] community level for councils and boards and so forth to provide use permits so we can provide rehabilitative programs for this population, but it–the mechanisms and the will and the tools to do it are in place.

Q. And so your answer to the question about whether it's your view that this churning pattern just postpones victimization and crime is yes, is that right?

A. My personal opinion is yes. We know it's not working. I mean, at 70 percent I think everybody understands we–and this is one of the reasons I'm flattered to be any part of the discussion. We all know we need to change the way we are thinking about this process and we are all engaged in that, including parole.

Q. Thank you. No further questions.

Judge Reinhardt: Does the CCPOA have any questions of this witness?

Ms. Leonard: No, your Honor.

The court: Thank you, counsel.

Redirect?

Mr. Lewis: Yes, your Honor. Thank you. Very briefly. Thank you.

Redirect Examination

By Mr. Lewis:

Q. Mr. Hoffman, there was testimony regarding that there would be a possible prisoner release order in this case.

[1770] If this prisoner release order included mentally ill parolees, what services do mentally ill parolees need that you currently attempt to provide through DAPO resources?

A. It runs the gamut from clinical psychologists inside our units, to counselors, to providing medications, to getting them to services outside of our units, to local services.

As we speak, we are working hard with local service providers in cities and counties across the state to provide these services. We have got about $9.6 million that we are working hard to get vendors and providers lined up for.

Q. And if additional mentally ill parolees were released in the community as a result of a prisoner release order, could CDCR provide the needed services for this increased population with its current resources?

A. No. The same logic would hold true; that this population, which is, obviously and understandably, work extensive and service intensive would need–we would need additional agents and, again, additional programming resources to do–to take care of them, or at least try to.

Q. And if these additional mentally ill parolees do not receive the services, are you concerned and, in your opinion, is there a risk of increased recidivism among them?

A. Again, the science would support that conclusion, yes.

Mr. Lewis: No further questions, your Honor. Thank You.

[Pages 1888-2095] VOL 10

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/11/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Tuesday, December 10, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. PAS, CSR 11916, CRR, RMR, RPR
Official Court Reporters, U.S. District Court

* * * *

PROCEEDINGS

[1891] December 10, 2008 9:21 a.m.

Judge Henderson: Okay. You may call your next witness when you are ready, counsel.

Mr. Mello: thank you, your honors. Paul Mello for Defendants.

Defendants call Scott Kernan, Undersecretary of Operations for the California Department of Corrections and Rehabilitation.

SCOTT KERNAN,

Called as a witness for the defendant herein, having been first duly sworn, was examined and testified as follows:

The clerk: State and spell your full name for the record.

The Witness: My name is Scott Kernan, K E R N A N.

Mr. Mello: Undersecretary Kernan has submitted a trial affidavit in this matter, which is defendant's exhibit 1002, on November 17th. We filed minor revisions to correct in exhibit numbers in that trial affidavit.

Undersecretary Kernan's education and professional background is summarized in paragraphs two and three of his trial affidavit.

* * * *

[1894] have come down between now and July.

Q. Of 2009?

A. Yes, sir.

Q. And Judge Reinhardt asked this question. As of August 29, 2008, CDCR had transferred approximately 4800 inmates to out-of-state institutions, correct?

A. Yes, sir.

Q. Does CDCR plan to transfer additional inmates to out-of-state institutions?

A. Yes, sir.

Q. How many more are currently planned to be transferred under current plans?

A. A total of 8,000, approximately 8,000 we currently have contracted. We are going to have 6,000 out by tomorrow.

Judge Karlton: I'm sorry. I just missed the question. My fault, Mr. Mello.

8,000 more or 8,000 total?

The Witness: 8,000 total.

By Mr. Mello:

Q. Mr. Kernan, has CDCR made efforts in the last few years to increase custody staffing to meet its needs?

A. Yes, sir.

Q. And specifically what have you done and what have you accomplished in that regard?

A. Well, the Receiver's office added 600 positions last year [1895] and are going to add 1800 this year. So about 2400 additional correctional officers dedicated solely for the access to care units, to use the Receiver's words.

And that's to provide services to the inmates, taking them out of the prison, getting them to medical appointments and mental health appointments within the prison.

Q. In addition to the Receiver's efforts to get the correctional officers, as far as healthcare access teams, has CDCR also increased its–its correctional officer staff separate and apart from the Receiver's efforts?

A. Yes, sir. I think it was a little more than a year ago we–or I anticipated or I projected we have about a 2,000 correctional officer shortage, and we had widespread overtime and we were difficulty at almost all of our prisons.

Today we have literally filled up all of our prisons with correctional staffing and we have–normally, this is the season for it, and we are going to cancel the January academy because we are actually overfilled at this point.

Q. I'm going to pull up defendant's exhibit 1235, page eight, please.

(Document Displayed)

Q. And this is a chart that was prepared and it demonstrates correctional officer numbers, both established positions and filled positions over time; correct, Mr. Kernan?

A. Yes, sir.

* * * *

[1941] duly sworn and examined as follows:

Judge Henderson: Before we begin, we are aware of the objections to certain parts of the declaration here, and consistent with previous rulings, we'll take that under advisement. So proceed.

The clerk: please state and spell your name for the record.

The Witness: James W. M-A-R-Q-U-A-R-T.

Ms. Johnson: Defendants have submitted three expert reports by Dr. Marquart which are marked as defendant's exhibit 1022, 1023 and 1024. Defendants now offer these exhibits into evidence.

Dr. Marquart's qualifications are described on pages one through three of his first report, defendant's exhibit 1022, and his curriculum vitae which is attached as exhibit a to that report.

Direct examination by Ms. Johnson

By Ms. Johnson

Q Good morning, Dr. Marquart.

A Good morning.

Q You have a PhD., correct?

A Yes, ma'am.

Q What field is your PhD. in?

A It's in sociology.

Q You are a professor at the University of Texas at Dallas?

* * * *

[1993] Violation process, right?

A That is correct.

Q And you agree that parolees should receive substance abuse education and job training, right?

A Yes, sir.

Q And you agree that the state should divert technical parole violaters and less serious property and drug crimes, right?

A It would be a good thing, yes.

Q And you support reducing the prison population through parole reform, correct?

A Can you repeat the question, please?

Q You support reducing the prison population through parole reform, correct?

A That's one way to manage it, yes.

Q So if you did use parole reform–you know that back end thing you were talking about with the hydraulics and different doors?

A Yes, sir.

Q So if they committed a crime and you had parole reform, it would not have the–if you had parole reform, even though they were committing crimes at the same rate, it would result in less people coming back into the prison system; isn't that true?

A It's a possibility.

Q Isn't that true?

A It's a possibility.

[1994] Q Everything in life is a possibility, correct?

A That is correct.

Q So your answer doesn't have very much meaning. So I'm asking you to be a little more definitive if you can.

A Can you repeat the question one more time?

Q Surely.

That would result–if the prisoners kept committing crimes at a certain rate but you had parole reform, it would result in less prisoners coming back into the system; isn't that true?

A One would hope that that's the case.

Q And in your estimation, in your opinion, the state should use multiple methods at the same time, such as reforming parole, early releases, and even changing the sentencing structure in order to reduce the population, right?

A That's right.

Q And as a general matter, it's your opinion that the California prison population can be reduced without adversely affecting public safety; is that right?

A We have to put in the proper tools and assessment techniques, as well as what I've talked about before in my reports and here, that programming inside, evidence-based programming on the inside, as well as having the proper resources on the outside in terms of housing, jobs, access to substance abuse, you know, all that.

[1995] Judge Henderson: Access to substance –

The Witness:–Abuse programs. Yeah, we don't want to have them have access to substance abuse, right.

But access to programming and the things that are going to help them transition back to the community, all of that together, one would hope that would help, yes.

By Mr. Specter

Q You have certain questions–you believe certain questions have to be answered about any population reducing plan, correct?

A Yes, sir.

Q Such as who would be released under what conditions and the like, right?

A Yes, sir.

Q You are confident, though, that if all the key stakeholders got together, rational effective decisions can be made so a safe plan can be developed; isn't that true?

A It would help, yes, sir.

Q It would more than help. You said in your deposition you were confident it could be done.

A Yes, sir.

Q You agree that the length–we've talked a little bit about this. You agree the length of incarceration is not related to recidivism; isn't that true?

A I guess so, yes.

Q So that means that reducing the length of stay in prison is

* * * *

[2004] strike team to implement the recommendation of the expert panel, is that right?

A. That's right.

Q. In Washington and Pennsylvania, did those states while you were there implement population reducing measures or controlling measures?

A. Yes, they did.

Q. In Washington that meant change in the law regarding technical parole violators, isn't that right?

A. Yes, it did. The law was changed to precluding technical violators from coming back to prisons.

Judge Reinhardt: Can we have the definition of technical violators, technical violations as far as those states were considered? I'm not sure that that means the same thing to everybody.

Mr. Specter: That's a good question.

By Mr. Specter:

Q. Who was considered a technical–who was considered a technical violator in Washington or what types of–

A. That would be any individual under supervision who, in fact, violated one of the conditions of their supervision.

Q. So it would be somebody who didn't commit a new crime, is that right?

A. That's correct. Non-Criminal Behavior.

Q. And those individuals would not be sent back to prisons, is [2005] That –

A. That is correct.

Q. Instead, what would happen to them?

A. They were–they were–there was a matrix in terms of the violations, the nature of the violations.

Depending on the nature of the violation, there was graduated sanctions that might be imposed. If it was a serious violation related to their past criminal behavior they, in fact, might do some jail time.

Q. And would some of the other sanctions be that they would participate in some sort of programs?

A. They might be ordered to be involved in a treatment program. They may be ordered to report to a day reporting center. There are a number of non-confinement sanctions.

Q. Okay. And in Washington was a risk assessment used for parolees?

A. Yes.

Q. And what was it used for?

A. We used an actuarial based instrument that would define the likelihood, risk of somebody reoffending.

Q. And once that you had information what–what did you do with it?

A. Well, we were faced, I think, in Washington, like any other system, with the recognition that not all offenders are the same, just like not all people are the same.

[2006] And the critical issue in terms of a lot of resources to address those offenders was to–to address–use those resources diligently on those offenders who represent the highest risk. So we wanted to assess who those offenders were.

Q. Okay. So that when they got out on parole, you could allocate your resources accordingly, is that right?

A. Yes. In fact, in–in Washington the issue became apparent when–we were, like any state, had limited resources.

So the question became, how can we best use the limited resources we have? We got together with prosecutors, with victim community, with law enforcement and basically came up in terms of the offender accountability act with a risk based system.

Q. And did this risk based system–when did the risk assessment, when was it done? In what stage of the offender's progress of the criminal justice system?

A. Well, at the very beginning. When the individual came–for example, the statutes in Washington mandated that the courts take into consideration risk in sentencing.

It certainly was done in relation to people coming either on parole or probation. It was even done in the prison system.

Q. And in that respect Washington changed its method by which it awarded prisoners credits, is that right?

A. That is correct.

[2007] Q. And how did the awarding of credits interact with the risk system?

A. A statute was placed where we would be authorized to allocate a greater amount of good time and earned time to those offenders who were low risk offenders, and a less amount of good time–for example, 50 percent, on those who were low risk. High risk offenders would only receive a third off.

Q. I see. And did the Washington credit method change for prisoners who were participating–who were conforming their conduct to the rules and participating in programs?

A. Yes. Actually, we had two forms of credits. One was good time, that was where they would be actually abiding by the rule of the prison and behaving themself. The other was an earned time credit, and that earned time was those individuals who were complying with the program requirements within prison.

Q. And were these credit–changes in the credit structure made retroactive?

A. Yes, they were. When they were implemented.

Q. Okay. Now, Pennsylvania, did they make any changes to the criminal sentencing structure?

A. Yes. In fact, Pennsylvania, like Washington and like California, was a determinative system. The sentencing guideline structure, that guideline structure in Pennsylvania initially provided for only total confinement.

So it was altered. The Sentencing Guidelines [2008] commission and subsequent legislature altered it to include intermediate sanctions and graduated sanctions in the community.

Q. So that meant that more offenders were diverted to the community, is that right?

A. That's right.

Q. And does the state do anything to encourage counties to provide alternative sanctions in the community?

A. Yes. Actually, we funded–we gave resources to those counties that would create programs to, in fact, divert offenders to the county system.

Q. How well did that work, if it worked at all?

A. No, it did work. It did work. In fact, the counties wanted to participate in the process because they wanted to ensure that those offenders in the community would have viable programs that with make a difference.

Q. The counties were satisfied with the program?

A. Yes, they were.

Q. Did any of these population reducing measures that you have described in both states endanger the communities in your opinion?

A. No, they did not.

Q. Do you believe there was any measurable impact on public safety, adverse impact?

A. No adverse impact.

Q. Do you believe it had a–what's the opposite of adverse?

[2009] Judge Karlton: Positive.

A. A positive effect.

By Mr. Specter:

Q. Thank you. A positive effect?

A. Yes. In Washington, the Washington state institute for public policy reviewed the impact on an ongoing basis. They actually were mandated when the offender accountability act was passed to do a full study in 2010. They did interim studies and all the interim studies have indicated positive progress.

Q. Now –

Judge Karlton: Please tell me what "positive progress" is?

The Witness: in other words, it was not having a deleterious effect on crime.

Judge Karlton: One argument that can be made is that given California's present system with its inability to provide meaningful programs in the prison system, if we reduce the significant weighed population, we might–so that we could provide programs, we might actually be improving public safety.

The Witness: And I agree emphatically with that. And, in fact, the research indicates that if you can provide programming and–there's evidence based program you can provide within the institutional environment that will, in fact, reduce the likelihood that they will reoffend. And it becomes even more powerful if there is after care programs once they are

* * * *

[2012] Q. And do you believe that's an appropriate policy?

A. The panel was recognizing that similar to credits, when you do prison and you are trying to influence their behavior, relative conduct or programming, that same system should exist in the community. When you supervise them, is to provide some ability to, in fact, incentivize their involvement in programs in the community and reward them for it.

Q. And you had experience with similar policies in Washington, correct?

A. That's correct.

Q. And what effect did those have?

A. Beneficial effects. I mean, the–the role of the Corrections Department in any system is to reduce the likelihood that they would reoffend. And I think you need–you need the capacity to, in fact, confine them when appropriate.

You need the capacity to intervene in their lifestyle and their thinking in terms of reducing the risks that they will reoffend, and you need to have a system of rewards and sanctions relative to that process.

Q. And did the panel believe that through the use of these measures, California's prison population could be reduced without adversely affecting public safety?

A. Absolutely.

Q. And you agree with that?

A. I emphatically agree with that.

[Pages 2096-2291] VOL 11

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/12/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Thursday, December 11, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. PAS, CSR 11916, CRR, RMR, RPR
Official Court Reporters, U.S. District Court

[2099] Thursday, December 11, 2008 9:23 O'clock A.M

PROCEEDINGS

Judge Henderson: Okay. You may call your next witness, counsel.

Mr. Sangster: good morning, your honor. Ed Sangster for the plaintiffs. The plaintiffs call Dr. Barry Krisberg. Barry Krisberg,

Having been called as a witness by the plaintiffs was first duly sworn and examined as follows:

The clerk: state and spell your full name for the Record.

The Witness: my name is Barry Krisberg, B-A-R-R-Y, KRISBERG.

Direct examination by Mr. Sangster

By Mr. Sangster

Q Good morning, Dr. Krisberg. Would you give the court a very brief summary of your educational background?

A I received a bachelor's from the university of Pennsylvania, got a master's from the same school in criminology, and, ultimately, a PhD. in sociology from Penn.

Q Would you give the court a very brief summary of your career in criminology?

A After getting my degree, I came out and taught at the [2100] University of California Berkeley in what was then the school of criminology, went on to work for the National Council on Crime and Delinquency where I'm still employed. That began in 1976.

I've also had a number of adjunct educational appointments during that period, most recent one at the law school at U.C. Berkeley.

Q What is the National Center on Crime and Delinquency?

A National Council on Crime and Delinquency.

Q National Council on Crime and Delinquency.

A It is the nation's oldest criminal justice research organization.

Q Have you published any books on the subject of criminology? A yes, I have.

Q How many?

A Four books.

Q Have you authored any peer-reviewed articles in the field of criminology?

A Yes, quite a number of over the years.

Q Have you received any awards for your work in the field of criminology?

A Yes, in 1993 I was selected by the American Society of Criminology for the August Vollmer award which is–

Q how significant is that award?

A It's their highest award for contributions to criminal justice. I've also been selected by the Jessie ball DuPont fund [2101] as their grantee of the year, and some other awards as well.

Q Have you been asked to provide any training to California counties in the field of criminology?

A Yes, I have.

Q Would you briefly describe that?

A Principally, my research, my training has involved training probation staff, and, in some cases, jail staff on issues related to classification and effective supervision strategies.

Q What studies of California prisons have you been involved with?

A I probably been involved in every major legislatively mandated study of the California prisons since 1980. The first one, I actually directed a study for the legislature on alternatives to the prison system. Subsequent to that, I was appointed to the blue ribbon commission on inmate population management, which was during Governor Deukmejian's administrations. More recently I was appointed to be part of an expert panel on prisoner rehabilitation in CDCR. So, again most of the major efforts I have been involved in.

Q Have you formed any opinions about the impact that prison population reduction in California would have on public safety?

A Yes, I have.

Q What is your opinion?

A My opinion is that, done properly, there is no reason to think that that release of prisoners from the California prisons [2102] ought to have any adverse effect on public safety.

Q What did you do in order to form your opinion?

A My opinion is based on a couple of–I guess three major components. One is I did an exhaustive review of research having to do with early accelerated release from other state prison systems over the last 20 years.

Q Let me just stop you there. Those were studies of what actually happened, not what people were predicting would happen; is that correct?

A That's correct.

Q Go on. What else did you do?

A Secondly, I looked at data from approximately 22 California counties that over the last ten years had released approximately 1.7 million inmates based on court ordered releases, and I looked at that as it was related to crime trends in the state.

Finally, I have been reviewing a number of studies and reports, including the report of the expert panel, indicating the most effective strategies to both select people for release and also manage them in the community.

Q Now, I want to turn your attention to your review of the studies of what actually happened when there was efforts to reduce prison population. So let's talk about the studies of the other jurisdictions. How many jurisdictions did you study?

A I looked at nine American states, city of Philadelphia, and also Canada.

[2103] Q How did you select those jurisdictions?

A I looked at–well, using the resources of the national criminal justice reference service, the national institute of corrections information center, the Bancroft library at U.C. and, also, the Rutgers NCCD James Cotton Library, which are pretty much the exhaustive literary sources, I attempted to assemble every article that was done on accelerated early release from roughly the 1980"s on up.

Q Did you find any articles on that topic that you did not consider?

A No, none that were–I mean, my criteria is it had to be real research, not opinions, and it had to have some data that you could analyze.

Q Did you have any personal involvement in studying population reduction in any of those jurisdictions?

A Yes, I was involved as well as the supervisor and also as a co-worker in a study that I think you've heard about, that Jim Austin talked about, in Illinois, the study of forced release in the Illinois Department of Corrections.

Q What was studied in connection with the other jurisdictions that you reviewed?

A Essentially, I was looking at two things. One was summarizing the information on whether or not the recidivism rates of people released early, how that compared to people released at the end of their regular terms. I also collected [2104] some data from the FBI to see whether or not during the period in which the release practices were taking place, there were any crime trend patterns.

Q What conclusions did you reach as a result of your studies of these other jurisdictions?

A With respect to recidivism–

Judge Karlton: Well, before you go there, we've had–we've now learned that recidivism means different things to different people. What do you mean by it when you talk about recidivism?

The Witness: Well, in these studies, Judge, they used a variety. Typically, the measure was parole failure, return to prison. That was the most typical measure used. In a couple of them they looked at arrests, but it was mostly failure on parole.

Judge Karlton: Does that mean, when you say "failure on parole," what has been referred to here as technical violations of parole?

The Witness: In most of these studies, it included both measures, new offenses and technical violations.

Judge Karlton: Thank you, sir.

By Mr. Sangster

Q Let me follow up on Judge Karlton's question.

Why is it significant to look at the recidivism rates when you are trying to evaluate the impact on public safety?

[2105] A I think the key issue is whether or not, by releasing inmates early, one sees an increase in the criminal behavior they engage in, as compared to persons who are released normally.

Q Did you find any jurisdictions during the course of your review that actually reduced recidivism rates as a result of population reduction?

A Yes. Most of the studies found no difference, but what we found in a study of the Philadelphia jail system in which they made provisions for drug treatment resources, that, in that case, those early paroled Philadelphia jail inmates who participated in drug treatment did better than those that did not participate in drug treatment.

The other significant study was in Florida where the state created a program called community control, in which, in lieu of going to prison, you would have intensive supervision and intensive services. And on that study, which was actually done by NCCD staff, again under my general supervision, the study showed that the inmates under this community control program have much lower recidivism rates than those that had been released from Florida prisons normally.

Q Now, I think the court has heard, and is going to hear, the opinions of some witnesses that releasing prisoners early will somehow reduce the deterrent effect of prison. What does your data from the studies show about the impact of early release on [2106] recidivism?

A Well, first of all, the research on deterrence suggests that marginal reductions in sanctions are not going to likely have an effect. That it is the certainty of punishment and the quickness with which penalties are brought to bear has a much bigger effect. There's a pretty large consensus that minor reductions are not going to make a big difference.

Q Based on your studies of the results of prison population in these 14 other jurisdictions, as well as your own experience, would there be an adverse impact on public safety if this court ordered the State of California to reduce its prison population?

A I don't believe so, provided that the plan that emerged was, you know, followed, sensible screening and good supervision strategies, and, where possible, resources were available, like drug treatment services.

Q You said –

Judge Reinhardt: what if there were no resources available?

The Witness: well, there's research indicating that you can slightly reduce recidivism rates simply by better screening and teaching parole officers how to better supervise offenders. There's studies from Florida, Wisconsin, and south Carolina indicating that simply training parole officers on how to do a better job will get you a net reduction in those recidivism rates. You will get additional reduction if, in [2107] addition to that, you were able to provide resources.

Mr. Sangster: I want to make sure, if I could follow up on your question, Judge Reinhardt.

By Mr. Sangster

Q The question, I think, is in order to avoid an adverse impact on public safety, do these programs have to be in place before the court can reduce the prison population?

A No.

Q Why not?

A Again, in a number of the jurisdictions that I looked at, Washington, Wisconsin, and others, these programs did not exist at the time of the accelerated release of inmates, and, again, there was–the recidivism rates were essentially identical and, again, no discernible changes in crime patterns.

Judge Karlton: May I interrupt for a moment? Yesterday we heard some testimony which, the witness, having reviewed apparently much the same material, I gather, said you couldn't make any conclusive judgment about anything, that the material was too–I'm not clear exactly why you couldn't, but, in any event, he was very firm about not being able to make a conclusive determination about anything.

Is your review of the material of the same judgment? I mean, obviously it's not. You seem to believe that the material clearly points one way or another.

The Witness: Well, my conclusion is based on the[2108] fact that, looking at these 14 separate and distinct articles, dissertation, and state agency reports, they're all in the same direction, and in some cases so–in social science, we would call this a meta analysis, when you find 14 studies and they are all reaching the same conclusion.

There's at least one study which, although a bit dated, I think is interesting.

California in the 1970's engaged in an experiment, which, again, is sort of the gold standard of research, in which random–based on a random sampling basis some inmates from the California Department of Corrections were released six months early. And the research done by the California Department of Corrections unit showed no difference based on that.

Now, it's pretty rare to get randomized experiments like that, but what we have in these 14 studies is a pretty broad range, different methods, different approaches, but all reaching the same conclusion.

By Mr. Sangster

Q Now I want to turn your attention to your study of what's actually happened in California. You said you studied the impacts of population control in county jails in California. How many counties did you study?

A The number varied from 20 to 24 depending on time periods. I tried to look at a ten-year time period, a five-year time period, and the last three years. So sometimes I didn't have [2109] the data for all those years.

Q What was the source of the information that you studied in connection with California jail releases?

A The data on court-ordered jail releases came from what's now called the corrections standards authority. It was submitted by the counties to CSA, and I pulled it right off the website of CSA.

Q Did you also review any interrogatory responses that were provided by parties to this litigation?

A Yes, I did.

Q Did you review any information about the crime rate in the counties–let me just end it there. Did you review any information about the crime rates in the counties you studied?

A Yes, I did. I contacted the California Department of Justice and was able to assemble data on serious crimes that, as part one offenses, in each of these counties for all those years.

And because these were jail inmates, I also wanted to look at misdemeanor crime trends. Misdemeanors, as you know, aren't reported as consistently. So in the case of misdemeanors, I looked at trends in misdemeanor arrests for the same period of time.

Q Now, did you consider your study of California study–California counties to be as rigorous as the other studies that you referred to in other jurisdictions?

[2110] A No, it was not as rigorous. The other studies involved individual cases randomly sampled from releases. In this instance, I was simply looking at aggregate information, total numbers, releases each year, and looking at that in relationship to total numbers of crimes.

Q Is the information that you gain from studying California counties nonetheless helpful in analyzing the impact of court-ordered population reductions in jails?

A I believe it is, because, for example, looking at the ten-year period, 21 counties, what we see is over 1.7 million inmates were released from California jails during this period of time. Again, those counties, specifically due to overcrowding orders during that same period of time, the number of crimes in California went down by 18–in those counties went down by 18 percent, serious crimes. And also misdemeanor arrests went down by 18 percent in those same places.

Judge Karlton: But at least one argument we will hear, apparently, is that misdemeanor arrests went down because the sheriff and police had no place to put them; the jails were so overcrowded. Can you really relate the downward trend on crime and the reduction in misdemeanor arrests to the cap that had been placed on the counties?

The Witness: I wouldn't go there. I would be far more confident that–that jail caps would not affect crimes reported to the police, the most serious crimes, rape, robbery, [2111] aggravated assault, car theft, et cetera. There's no reason that people stop reporting crimes to the police.

Judge Karlton: That's why I said misdemeanants.

The Witness: Yeah. The only reason I looked at misdemeanants is, I guess the argument is since most jail releases are most likely to be misdemeanants, I wanted to see whether or not there was a sudden increase in misdemeanant crime in the state, and there was not.

By Mr. Sangster

Q You said you studied 1.7 million people released over a ten-year period. Did you also study the number of people who were released from California counties during the five-year period between 2001 and 2006?

A Yes, I did, and during that period, a little over three-quarters of a million inmates were released from–I have data on 22 counties. And during that period of time reported in those counties was essentially unchanged.

For the last three years, 2004 to 2006, there were over 400,000 inmates released based on court orders from these counties, and during that period of time the number of reported crimes declined by seven percent.

Q Did all of the counties show consistent results?

A No. One of the things I did was look at each one of these counties individually to look at these trends and put them together.

[2112] Q What did you find as a result of looking at them individually?

A What I found is there were some variations, but there was no consistent pattern. Release didn't lead to a crime reduction, but it certainly did not lead to a crime increase.

What I found, for example, was, you know, let's take the last three years. I found 13 counties where releases were up and crime was down. There were another eight counties in which crime was down and releases were down. And then there were three where releases were actually up and crime went up.

We also–I also looked separately at Los Angeles, Orange, and San Diego to see whether or not this trend had anything to do with the larger counties, and, again, no consistent pattern. When you put this on a scatter diagram and you look at these things from a statistical point of view, there's just no discernible pattern.

Q What opinions did you reach as a result of your study of court-ordered population reductions in California counties?

A That it did not appear to have any adverse effect on crime in California.

Q My prior questions have been retrospective, in other words, dealing with what's actually happened in the past and been observed. Now I want to turn your attention for a moment to your opinions about what would happen in the future in this case.

* * * *

[2131] Work with, that the severe overcrowding in California prisons is leading to tremendous levels of violence, is inhibiting the capacity to deliver rehabilitation services.

So I think reducing the crowding and cutting down on the violence and actually introducing rehabilitation should bring that California recidivism rate down to much more what we're seeing in other states, which is a much, much smaller recidivism level.

Judge Henderson: Nothing further from–Mr. Sangster: no, your honor.

Judge Henderson: Okay. Thank you for testifying, Dr. Krisberg. We'll take a 15-minute recess at this time. (recess taken.)

Judge Henderson: call the next witness, counsel.

Ms. Keck: Good morning, your honors. Ann Keck, deputy county counsel on behalf of the Sonoma county intervenors, and I would like to call David Bennett to the stand.

Judge Henderson: Step forward and be sworn in, Mr. Bennett.

David Bennett,

Called as a witness for the defendants herein, having been first duly sworn, was examined and testified as follows: the witness: I do.

The clerk: Please have a seat. State and spell your

* * * *

[2189] community, then what is at stake here is the overall integrity of the process.

We can't build enough beds and lock enough people up for a long enough period of time to impact the crime rates. We have to rely upon the integrity of the process. And so simply releasing individuals from prison early is going to have a significant impact upon that integrity issue and on everything that we are doing in the criminal justice system.

Q. But do you believe that it's possible to reduce the prison population safely and effectively?

A. Absolutely.

Q. And how–how would you say that could be done?

A. A well-thought-out plan needs to be implemented, a plan that has three primary areas, that covers three primary areas.

First of all, the introduction into the system, the expansion, the use of programs that are based on evidence-based practices.

Second of all, the use of a risk and needs assessment in order to set parole supervision conditions.

And, finally, the implementation. I know there has been some work in this area, but it has not been implemented. The implementation of a structured sanctions process for both probation and parole violators.

Q. I would like to have you explain more of each of these to the court in turn, so let me address your attention to the first [2190] part of the plan that you just stated, the programs need to be instituted.

Could you explain for the court what you mean by that and what would be the impact of that recommendation?

Judge Reinhardt: Can I ask you one question here?

When you say could you reduce the population with your programs, are you–are you saying you could reduce it by 50,000? And if so, over how long a period?

The Witness: Your honor, I don't have a number or a time period. I'm proposing a process and a structure in which to reduce that prison population.

A lot of work is going to have to be done in order to put in place the specificity and as I continue talking, to put in place the needed partnership between the State of California and its counties to carry this out.

Judge Karlton: Following Judge Reinhardt's question, is there any way that you understand that we can reduce the population so as to affect the ability of the system to provide adequate medical and mental health healthcare without releasing people?

The Witness: My understanding of the overcrowding situation in the prison system is that it absolutely will require the release of inmates in the facilities in order to be able to provide that level of care that's required.

Judge Karlton: So that some form of a prison release [2191] rder will be required somehow?

The Witness: Yes. What I'm talking about here this morning, and as I walk into the three parts of this plan, is not just a release order, but the development and the introduction of a plan that a byproduct will be a managed prison population.

Judge Karlton: go ahead.

By Ms. Keck:

Q. Let me direct your attention to the first part of the plan that you mentioned, which is the programs necessary to support the release.

Could you please explain to the court what it is you mean by that?

A. It's a combination of programs. Right now there are some programs that CDCR offers. There's very little incentive for prisoners to participate in the programs.

There's no linkage whatsoever with the programs that they participate in while in the institution, and they are released back out into the community.

There is no structured process for making sure that the basic issues that we are dealing with in a correctional system are being addressed; the alcohol, drug, mental health issues; the lack of education and the problems with employment issue; the housing issues.

There is no putting together of a plan. There is holding individuals in the prison system and releasing them.

* * * *

[2194] happen again, then we need to individually tailor how we handle and address that specific individual's needs and problems.

Q. Are there examples currently in the State of California where this type of individual assessment and addressing the specific needs of the population is being conducted currently?

A. Well, Sonoma County is in the process of implementing the use of a risk and need assessment throughout its entire system. It comes online this next week on the juvenile system, and in march on the adult system, with that risk and needs assessment as being applied to the individuals in the local criminal justice system to help determine, either at the juvenile level or the adult level, the level of supervision and the programs that the individuals are going to be involved with.

CDCR has done some different things with risk and needs assessments. It's in the process. It's growing. It's happening. It just hasn't been fully implemented and there hasn't been that formal linkage with the level and amount of supervision of individuals released on parole.

Q. And when you talk about there being structured sanctions, is the only sanctions you are referring to just a return to prison if there is a violation of parole or is it something more?

A. We need to do a lot more. What we have learned-and we knew this all along, but drug court has taught it to us again.

It's not the severity of the sanction that's Important. What's important is the certainty and the immediacy [2195] of it That an offender who is out, either on probation or parole, that there is an understanding, there are certain rules, there are certain conditions that have to be followed. There has to be the ability to monitor those conditions and then there has to be the consequence for their actions.

We don't just simply wait till the level of failure rises to the level, whether a zero tolerance program is in place or probation and parole officers have some discretion as to when to violate the offender, violate them and simply return them to prison, have them held on what the data tells us an average of 120 days, circulate them through the process back out again.

We need to have meaningful, immediate, certain sanctions. And it doesn't have to be a return to prison. We can develop sanctions at the local level.

We can keep individuals locally in this partnership between the state of California and it's counties. We can have a more effective sanction without interrupting individuals lives and returning them to prison.

Q. Why would a prison population reduction plan that contains the three elements you describe significantly lower prison population? Why do you believe they would be effective?

A. Because we are interrupting the cycle of crime. We are becoming involved with the individual, with their issues and with their problems.

No longer one size fits all. No longer simply taking

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[2201] counties.

The Witness: It does, but it's my opinion that the state is already spending substantial amounts of dollars in its ineffective broken criminal justice and corrections system; that by reprioritizing its dollars, by retargeting and working on upstream issues so that we get out ahead of the problem, that's the only way that we are going to be able to solve this problem without catastrophe.

Judge Reinhardt: And how long if your steps were in effect–are you saying if these steps were in effect, then 50,000 prisoners could be released?

The Witness: I'm saying that if this plan were adopted by the State of California, that the population could be brought down in a systematic way without having to enter a release order.

Judge Karlton: I thought you just said–never Mind.

By Ms. Keck:

Q. Perhaps you should clarify to the court. Are you recommending as part of your program that there be a population cap or other general release order entered with respect to the state prison population?

A. I understand it's a $64,000 question here this morning.
Judge Reinhardt: well, to answer the court, the cap if your program would bring it down, what harm would [2202] there be to a cap, if that would be the effect anyway?

The Witness: The issue and the issue I think that Judge Karlton was reacting to was my comment earlier about within the institutions, the providing of the necessary constitutional medical and mental health services can't be provided with today's overcrowding.

It's going to take some time to implement my plan. It's going to take some time to put this in place, the overall planning process as well as the implementation, once the planning has been done.

And so we are kind of between a rock and a hard spot right now because we have the overcrowding at the level that we have. We have the difficulties within the institution, and we don't have the mechanisms in the community to have to implement a release order in such a way that it's not going to impact the local systems.

By Ms. Keck:

Q. Would a population cap by itself be sufficient to both resolve the problems at the overcrowding at the state prison level as well as address the concerns in the community?

A. Well, clearly, a population cap will address the overcrowding in the state prison.

Whether–depending upon how the cap is implemented, either the front door is going to be closed or the back door is going to open up. In any event, it's going to have a negative

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[2207] The Court: you may call your next witness.

Ms. Whelan: your honors, we recall Dr. Pablo

Stewart.

Judge Henderson: You are still under oath.

Ms. Whelan: for the record, we previously offered both of Dr. Stewart's expert reports into evidence in this case, including Coleman docket numbers 3217, which was his November 9 –

Judge Karlton: other than taking our time, why are you repeating it?

Ms. Whelan: Sorry, just for the record. I can move On.

Judge Karlton: I'm sorry, I didn't mean to speak sharply. Excuse me.

Direct examination by Ms. Whelan

By Ms. Whelan

Q. Dr. Stewart, one of the issues that you evaluated in this case was whether other relief, meaning relief other than population reduction measures, could succeed in remedying the constitutional violations in the delivery of medical and mental health care. What did you conclude?

A. I concluded that, due to the extreme nature of the overcrowding, which negatively impacts all aspects of the mental health and medical care system that is currently causing Coleman class members needless suffering, as well as death, that the [2208] only remedy that would help the system to move into constitutional compliance would be a population reduction.

Q. And could you explain the specific findings you made that led you to that conclusion?

A. There was a couple findings that led me to that conclusion. There were two of those that–excuse me, this sounds a little funny from here. Is this all right?

Judge Karlton: It's all right for me.

Judge Henderson: It's okay.

The Witness: Excuse me.

Two of the findings that I base that opinion on were also two of the findings that I based my opinions that overcrowding is a primary cause of the constitutional violations, and that is the persistence of the violations after years of very close court monitoring.

And, also, the special master has stated in several places that the progress that was made early on in the Coleman matter has been undermined by current population pressures that exist.

By Ms. Whelan

Q. And defendants argue in this case that they have plans to fix all of these problems. Have you had an opportunity to review those plans?

A. Yes, I have.

Q. Can you explain briefly why you do not think those plans [2209] will adequately solve the crisis?

A. Well, the main reason is that these plans will take years to implement, if they are even able to be implemented at all, given the current degree of the population pressures.

So the Coleman class members are suffering now. They're–and any plans that would come online years down in the future wouldn't do anything to address that issue.

So it's my opinion that the only remedy, since overcrowding, in my opinion, is the primary cause of the constitutional violations, that any remedy would necessarily need to include a population reduction.

Q. You discuss in your report your belief that the state must make substantial reductions in the prisoner population. Do you have an opinion about what target population should be achieved from a medical and a mental health perspective?

A. From a medical and a mental health perspective, and–I have run jail medical situation programs, and mental health programs necessarily need to be run at under 100 percent so you're able to respond to the given needs of a system on any given day. You need to move people quickly into a mental health crisis bed. You need to move someone to an acute care bed.

So any population reduction that would occur would have to be of sufficient quantity to allow the mental health units to exist at less than 100 percent of design capacity.

Q. You also state in your August 15 report that Coleman class

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[2211] over the course of two years, could you explain what effect that would have on the Coleman class?

A. Well, if we take just the 50,000 number, and given that approximately 21 percent are Coleman class members, the CDCR population, then that means out of this 50,000 reduction, 10,000 would be Coleman class members. And out of the Coleman class members, the overwhelming majority, 85 percent, are in the 3CMS level. So that would correspond to 8,500 people from the 3CMS.

And the 3CMS level currently in the Department of Corrections receive, quite frankly, minimal care. They are seen occasionally for medications. They may have a case manager visit. And that would translate to the community as needing similar levels of treatment, medication management possibly, maybe some sort of case management services. That would be the extent that they would need.

Q. What about in terms of class members at the enhanced outpatient or DMH levels of care?

A. Again, looking at the numbers that currently exist, the EOP level of care is 13 percent of the Coleman class, and in a 50,000 prisoner reduction, that would mean 1,300 people. And that would be 1,300 people possibly released–would be released over a period of two years.

Currently, in the state of California, looking at the DMH website for its most current data, there's over 658,000 people receiving mental health services at the county level, and [2212] out of those 658,000 people, over 69,000 receive any sort of day services, day treatment-type level that is roughly equivalent to the EOP.

We are talking 650 people added to that cohort of over 69,000 in a given year. I think that they can be incorporated into the current system as it exists, even without any augmentation.

And then if you look at the DMH level of care, again, that's around two percent of the Coleman class. That corresponds in this 50,000 prisoner reduction number to 200 people.

Now, assuming that once they are released from prison over the course of two years these 200 people would continue to require initiate care, and I don't think you can necessarily assume that, once they are removed from the very difficult conditions that they are in now, it's very reasonable to suspect that their mental health conditions would improve.

But even assuming 200, we are talking about 100 additional people over the state of California in a given year that currently treats over 43,000 people in inpatient care in a given year, that's 100 in a system that currently treats 43,000.

Q. You also state in your August 15, 2008 report that if the state increases resources to improve mental health services on parole and in the communities, it would actually improve public safety. Can you explain what you mean?

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[2216] abuse drugs, they are going to be too violent, we don't have enough services for them, and if we are forced to treat them, boy, all hell is going to break loose. Well, it didn't. And that was the first example.

You know, there has been other examples throughout my career where the community mental health makes a whole big fuss about treating people that have concurrent substance abuse problems. You know, the same examples are given. It's going to overwhelm our system. We don't have enough resources; they are too violent; we can't care for them adequately; public safety is going to go down the tubes. And, in fact, it didn't.

Right now the standard of care is that people with mental health and substance abuse problems are treated concurrently in the community mental health system.

So I can understand on one level. I can understand their degree of concern, as I would be. But I think it's, quite frankly, overstated.

Q. And defendants have argued in this case that the reduction that plaintiffs seek, again approximately 50,000 over the course of two years, will not benefit the Coleman class. Do you agree with that?

A. I wholeheartedly disagree with that.

Q. And can you explain why?

A. A significant reduction, if we look at 50,000 as an example, 50,000 people reduced from the current CDCR population would [2217] have a significant impact on the Coleman class.

Just for example, there are general population yards at Salinas valley state prison that have basically been in lockdown for several years because there's too many inmates and there's not enough guards to safely guard them. So they lock everybody up in their cells, and among that group of people that are locked down are Coleman class members, that, when I interviewed, talked about the extreme stress and the worsening of their mental illness because of their being locked down.

Another immediate relief that would be accrued for Coleman class members, if there were the 50,000 inmate population reduction would be, hopefully, the elimination of these horrible dormitories that exist in dayrooms, in gyms, in corridors and hallways where Coleman class members are currently housed.

And I certainly observed, and it was confirmed by the special master, that there's so many people that it exacerbates the people that started off with mental illness, and it creates new mental illness. So any population reduction would have–immediately have a beneficial effect on the Coleman class.

Q. And what about in terms of defendant's plans to fix some of these problems, how would the reduction affect those plans?

A. Well–

Ms. Tillman: objection. Asked and answered.

Judge Henderson: Overruled.

[2218] The Witness: Look at the different aspects of the plans, the bed plans, for example, the construction plans. The population at large feeds in to the system that then requires inpatient care.

So if you look at the numbers for mental health crisis bed referrals from July and August of this year, a significant number were from 3CMS and, also, over 40 percent and around 10 percent give or take were from the general population.

If you lower the general population, if you lower the numbers, there are less people that would be requiring mental health crisis beds, and then mental health crisis beds are then feeding into the intermediate care facilities which then feed into the acute care. It would have this cascading positive effect by lowering population.

And it may, quite frankly, be the only remedy that's going to help the state meet their requirements for adequate number of beds at different levels of care.

By Ms. Whelan

Q. You also talked about reception centers being a problem but could you talk about how a reduction may assist those, as well as the main line institutions?

A. The reception centers–the reception center that I toured was DVI. And it was–I don't have the right adjective how crowded it was. I believe it was operating at over 200 percent design capacity.

[Pages 2292-2503] VOL 12

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/15/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Friday, December 12, 2008

(Appearances on following pages)
Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. Pas, CSR 11916 CRR, RMR, RPR
Official court reporters, U.S. District court

[2315] A Yes, it is.

Q Is that consistent with your experience in the field?

A Yes, it is.

Q Now, you also say in your report that the average inmate has committed 12 crimes before their current arrest. What was the source for that information?

A there was a rand study that was conducted, and I believe it occurred in two states, one of them being, I believe, Wisconsin, the other new jersey. And in one of those, one of the studies, it showed that before an individual was ever arrested, and this was the year before being incarcerated, they had committed 15 felony crimes, and there was another study that stated that they had committed 12, and that was self reported for individuals that had been convicted.

Q We've heard from other witnesses that those numbers are highly inflated. Do you agree with that?

A No, I do not.

Q And why not?

A I think generally there's–quite often, I should say, that those numbers are probably underreported. And there has been other studies that show that those numbers are underreported, that in some cases individuals are committing hundreds of crimes before they're ever apprehended, and what I prepared for my report was a very conservative estimate.

Q All right. Thank you.

[2316] Ms. Barlow: now, we do have, your honors, exhibit 653 and 637, if we could put up the first page 653?

(Document displayed.)

By Ms. Barlow

Q Is this one of the articles that contains the data you relied on for this information?

A There was an NIJ study that was conducted that showed a large number of crimes in addition to the research that we provided from the rand study.

Q If we could just put up the next page, second paragraph under "annual offender rates"?

A I think it would be the next paragraph.

Q Well, this one–I'm sorry.

That included inmates from California, correct?

A That's correct.

Q Okay. And then, yes, the paragraph under "the table represents". Okay.

> "When summed across appropriate categories, the study found that inmates average between 187 and 287 crimes per year, exclusive of drug deals."

Was your calculation about the number of crimes committed also exclusive of drug deals?

A The research that I relied on, yes, it was exclusive of drug arrests, drug crimes.

[2317] Q And also number 637?

(Document displayed.)

By Ms. Barlow

Q Is this also one of the studies–or summaries of a study that you relied upon?

A Yes.

Q If we could go to bates page 200, paragraph beginning "third"? This is a recitation of the rand study showing 15 crimes excluding drug crimes, correct?

And then in the next two paragraphs down–I'm sorry. Is that correct, chief?

A Yes.

Q And also were you looking at the studies referenced here from New Jersey and Wisconsin?

A That's correct.

The Clerk: Five minutes, counsel.

By Ms. Barlow

Q Now, if you could tell us why you believe, chief, that the reduction in prison population of 52,000 that's proposed is going to create a public safety hazard; could you tell us why that is?

Judge Henderson: For Fresno?

Ms. Barlow: I'm sorry?

Judge Henderson: For Fresno?

Ms. Barlow: Actually, your honor, his report talks [2318] About Fresno and the central valley.

Judge Henderson: okay.

The Witness: The–when individuals are released from prison, there is a high likelihood that they are going to continue in their criminal lifestyle. In fact, in California I believe that number is 70 percent or greater that recidivate. And when we look at if 52,000 inmates are released back into our community, depending on that timeframe, we have information that about 3.9 percent of those individuals would more than likely be placed in Fresno County. Of those, about 80 percent would come into the city of Fresno, minimum maybe 80 percent. That would be just over 1,600 inmates released back into the city of Fresno prematurely. If we furthered what we've already said, that there is a 70 percent likelihood that they would reoffend—

Judge Karlton: No. That they would recidivate.

The Witness:—recidivate. And if we look at the fact that those individuals would likely commit at minimum 12 crimes before they were apprehended, that would mean there would be a substantial number of crimes committed in the city of Fresno, upwards of 13,000 crimes over that three-year period.

Judge Reinhardt: That would be committed prematurely as opposed to committing them several months later.

The Witness: yes, sir. They would be committed at some point during that three-year period. I don't know—you know, I know that there's—

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[2348] but to state the obvious, and then restate it, and then restate it, and then–it's just a profound waste of time. This is cumulative. You got anything new that you want to ask?

Mr. Lewis: thank you, your honor. I'll be seated Now.

Cross-examination? Do you want to take break? Okay. We'll take a 15-minute recess.

(Recess taken.)

Judge Henderson: You may proceed with cross when you are ready, counsel.

Mr. Specter: Thank you, Your Honor.

Cross examination

By Mr. Specter:

Q. Good morning, Mr. Dyer.

A. Good morning, Mr. Specter.

Q. As I understand your position, it's that a prisoner release order would result in more parolees in your city and county for some period of time, correct?

A. That's correct.

Q. And this would dramatically increase the crime in your community, is that right?

A. That's correct.

Q. And so you would expect that as the number of parolees increase, the crime rate would increase, right?

A. Generally, yes.

[2349] Q. But that hasn't happened, has it? In fact–well, let me ask you this. Between 2003 and 2007–remember we went through this during your deposition?

A. Yes.

Q. (continuing)–there was a 28 percent increase in the number of parolees and crime went down during that period, right?

A. All but 2005.

Q. Right. And so what I did–you estimate that there are going to be about 1900 parolees from a prisoner release order, right?

A. That was based on the initial number of 40,000, yes.

Q. So we'll take around 2000 would be a fair estimate? Yes?

A. Yes.

Q. Okay.

Mr. Specter: Could we please have the first table?

(Document displayed)

By Mr. Specter:

Q. So, Mr. Dyer, this is a chart based on the number of parolees, new additional parolees which are released to the county of Fresno, and it also has the violent crime rates.

Ms. Barlow: I'm sorry, your honor. I'm going to object. I don't know where this document came from. I've never seen it before. I don't know who prepared it. I don't know where it came from.

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[2352] But I hope when they get to question her, they can–there won't be any more objections, just like we have done in other exhibits that they have requested that we . . .

Judge Henderson: proceed.

By Mr. Specter:

Q. So my question was, Mr. Dyer, even though there was an influx of parolees about that–during that time, there were–crime went down in all the years except 2005, isn't that right?

A. Yes.

Q. Okay. So, in fact, you have a page on the Fresno website, do you not, the police department website?

A. Yes.

Q. And you claim that Fresno has enjoyed the lowest crime in 43 years, isn't that right?

A. That's correct.

Q. All right. So now i would like to show you a powerpoint demonstration, which is all we do on these powerpoints is the spreadsheet makes some of these charts into graphs.

(Document displayed)

Judge Karlton: again, you are going to somehow or other either satisfy the defendants or put the person on the stand?

Mr. Specter: Yes, Your Honor.

Mr. Mello: Your honors, Paul Mello one last time. Can we just have a standing objection for lack of

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[Pages 2504-2718] VOL 13

[1] UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 12/19/2008]

No. CIV S-90-0520 LKK JFM P
THREE-JUDGE COURT

Ralph Coleman, *et al.*,
Plaintiffs,
v.
Arnold Schwarzenegger, *et al.*,
Defendants.

No. C 01-1351 TEH

Marciano Plata, *et al.*,
Plaintiffs,
v.
Arnold Schwarzenegger, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Thursday, December 18, 2008

(Appearances on following pages)
Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. Pas, CSR 11916 CRR, RMR, RPR
Official court reporters, U.S. District court

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[2509] Judge Reinhardt: we might be willing to discuss it with you.

Mr. Sangster: Currently, we think we have three witnesses on–the defense has three witnesses–or two witnesses, the plaintiffs have a rebuttal witness, for tomorrow. So even if somebody from today slops over, I don't see any chance we are not going to finish tomorrow.

Judge Henderson: Thank you. You may begin. Call your witness when you are ready.

Mr. Lewis: Good morning, Your Honors. Kyle Lewis on behalf of the state defendants. Defendants now call Gale Bataille.

Gale Bataille

Having been called as a witness by the defendants was first duly sworn and examined as follows:

The clerk: state and spell your full name for the Record.

The Witness: my name is Gale Bataille, G-A-L-E, last name B-A-T–A-I-I-L-E

Mr. Lewis: Good morning, Ms. Bataille.

For the court's knowledge Ms. Bataille's expert reports were filed and marked as trial exhibit 1025 and 1026, and her qualifications are set forth in her curriculum vitae which is exhibit A to 1025.

[2510] Direct examination by Mr. Lewis

By Mr. Lewis

Q Ms. Bataille, What is your current position?

A currently, I'm a consultant with several statewide organizations, the California mental health directors association and the California institute for mental health.

Q Are you also a member of a judicial council committee?

A Yes. I serve on the California judicial council's criminal justice and mental health task force, which is charged with coming up with some better solutions to the criminalization of mentally ill folks in this state.

Q And in the course of that committee and those other consultancies you work on, what are your duties generally?

A in terms of the judicial council committee, I actually serve on two task forces within the committee, one of them on co-occurring disorders, and the other on reentry or early post-adjudication services.

With the California mental health directors association, my primary role with them is as consultant on criminal justice policy issues.

Q And prior to your work with those organizations, did you work for any mental health department in the state of California?

A I worked for three mental health departments and one private nonprofit agency. I served as deputy director for alcohol, drug [2511] abuse and mental health services for nine years in contra Costa County. I served as mental health director for Solano County, and I served as mental health director in San Mateo County. Early in my experience I ran a small residential treatment facility in Alameda County.

Q What is your educational background?

A I have a BA with honors in psychology from Oberland School, and I have a master's degree in social work from San Francisco State university.

Q You were retained as an expert for defendants in this case regarding the potential effects of a California prisoner release order on county-based community mental health systems and mentally ill persons that it serves, correct?

A Yes, I have–was.

Q And what is your opinion regarding the potential impact of a prisoner release order on California's county-based mental health systems and the persons it services?

A My opinion is that a–particularly any kind of accelerated release order would have a detrimental impact, not only on the individuals released, but on the county, and, I would assume, state parole outpatient systems unless there is substantial availability of increased funding and increased services, as well as, really, the capacity to plan and fully execute those services.

I can say more, but California's mental health system

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[2516] Actually, many of them, we will only find out later, actually are on parole, so we don't necessarily know when they come in the door because they sometimes would prefer to use the public mental health system than parole outpatient. It depends on the individual.

Q Do you have an opinion regarding, I guess, the amount of supervision or treatment services that should be made available to the most highly needing criminal mentally ill offenders coming out, such as the EOP or high levels of care you described?

A Yes, I do. The EOP population–and then there is some more severely disturbed populations that really require intensive inpatient care. But the EOP population in general needs structured care and needs care that doesn't depend on them voluntarily remembering and keeping appointments and voluntarily going out and finding their own housing. They really need what we tend to call in mental health intensive wraparound services. Actually, that's been recognized in the work that was done in California, really following up on—excuse me—the AB 900 prison reform legislation.

There have been several bills that have been introduced, and vetoed, I think because of financial issues, but were introduced by senator Steinberg that really funded those kinds of intensive wraparound services, and they are–they probably cost on an average per individual $15 to $30,000 a year [2517] and really need 24-hour availability of care.

Q Are you familiar with CDCR's mental health parolee outpatient clinics?

A Yes, I would not say I have, you know–I haven't gone in and out of those clinics a lot, but I am familiar with the system.

Q Based on your experience, are the parolee outpatient clinics able to meet the needs of an additional 10,000 persons that may be released as a result of this prisoner release order requiring mental healthcare?

A No. What I can comment on at this point is that very much within my experience, and particularly when I was director in Solano County and in San Mateo County in the last 18 years, it was not at all uncommon for parole outpatient clinics to attempt to refer individuals who needed more intensive care to our system.

It was also not uncommon for them to say to a parolee, as by self-report that we heard from the parolee, go on over to county mental health and see if you can get in the door. It was commonly known and happens.

Q Does this lack of access by parolees to parolee outpatient care cause you concern in terms of the effects it might have on county health systems?

A Yes, it does. And let me give a little bit more specifics. The adult outpatient parole system has done various [2518] reports. The one that I've most recently seen was, I believe, march of 2008, and that report discusses both rates of recidivism for the Coleman class of mentally ill prisoners and parolees, and it also lays out staffing ratios that are currently in those clinics. And having worked in county mental health systems for, as I said, 28 years, I'm very familiar with what are generally accepted caseload of staffing, and I, quite frankly, was a bit surprised at the kinds of ratios that currently exist.

For example, I believe that there is–for every 570 parolees who are already classified as mentally ill, there's one psychiatrist. So it's a one to about a 570 ratio caseload. Similar kind of size for psychologists. And a one to, I think, 170, -75 for social workers who would help to manage the cases. That is dramatically higher than any caseload that can effectively work with folks, in my experience, in the public mental health system.

One of the things that report documents is that there is an increase in recidivism rate if there is not immediate contact with treatment and intensive follow-up. So—there's been a UCLA research study on the parole outpatient continuum that basically documents that as the frequency of contact and the immediacy of contact goes up, the recidivism rate drops, and the reverse is true.

Q And do county mental health-based systems have the capacity [2519] to meet an additional influx of mentally ill offenders that might not be able to get care at the POC's?

A I would say that that is absolutely not within the capacity of county mental health systems currently. I've already stated that county mental health systems are struggling with being able to meet the capacity of the most seriously mentally ill population currently, and that is not—let me just add that's not just a matter of having enough money to do it, but literally whether there are enough trained professionals out there to bring in—even if we had the money, there are not enough psychiatrists in the state, and that's one of the most critical shortages for nurses in the mental health system. There are significant vacancy rates.

I'm fairly familiar with that because I've also done work on what we call the workforce capacity crisis in California.

Q In addition to not having staffing, are there also funding problems for local county mental health systems?

A Yes. I'm not going to—unless you want me to, I won't go into all the funding streams that fund the public mental health system, but just to say that one of the key streams of funding is based on California's sales tax and vehicle license fees, and we all know what's going on in the economy right now. That's taken a nosedive and, frankly, has not grown over the last decade and a half since that's been in place to keep up with [2520] what the actual cost of doing business over that time is.

Q In one of your expert reports you highlight the importance of adequate planning to have mental health services in place prior to a release of Coleman class members. What would such planning entail?

A I did cite that, and, in my opinion, doing adequate planning means assessing–and I think there's some data to help with this, but assessing where the anticipated releases will be grouped, I guess, if you want to say that, so that, for example, we know that L.A., riverside, San Bernadino and San Diego county, if you take those four counties together, they would have over 50 percent of the released parolees in the state. Currently due, and one can anticipate that any additional, release would have a similar kind of percentage impact.

And so we really need to look at those larger counties and what it would take for them to have capacity to work with a parole outpatient system and provide services that may not be feasible within the current parole outpatient system. So that's one part of the planning. It also simply takes time to, based on your assessment of the needs, to–it takes time to determine what programs need to come up and to put them in place. And I think that if I've had a fault as a mental health director in my career it's because I have always been overly optimistic about how quickly we can bring programs up and operational.

* * * *

[2534] Q And you don't hold yourself out as an expert on anything about the internal operation of the prisons, do you?

A No. And that isn't what I was retained for.

Q You are not providing the court with any opinions at all about mental healthcare in the prisons; is that right?

A That's not my intention, no.

Q I'd like to read you a short statement and ask you if you agree with it.

> "Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and, therefore, efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive. Even then, most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems." Do you agree with that statement?

A if the summation of the statement is that local systems, [2535] even though they are underresourced and underfunded, could improve services to folks involved in the criminal justice system through collaboration, absolutely. That's what many, many California systems are trying to do, and that's actually what we are trying to help provide input on through the state judicial council. Mental health courts, collaborations with probation departments, all of which we were able to do in San Mateo County, and with local police departments, absolutely improve services. They don't absolutely, though, address a lack of capacity to provide services to everyone who needs them, including the most seriously mentally ill.

Q You testified about how county mental health prioritizes services and how, if there's a prisoner release order, there's the danger they would prioritize services to the released mentally ill prisoners at the expense of the general public?

A Yes, I did.

Q And you know that 10,000 people per month are released right now from California prisons to the communities?

A Yes, I do.

Q And you know that using the 20 percent estimate, about 2,000 of them are persons with mental illness members of the Coleman class?

A That are newly released each month.

Q That are newly released each month.

A Because the total parole outpatient system monthly average [2536] Is more like 22,5-, 23,000 of mentally ill, so you add—so it's 2,000 a month new within that system.

Q Yes. You are aware that 2,000 a month new come into your communities?

A Yes.

Q From the prison system?

A Yes.

Q Do the mental health directors prioritize them for service now?

A currently, in California there's some variability, but, traditionally, in California, it's basically operated as a parallel system. So that, in general, parolees receive their care, and have received their care, from the parole outpatient system.

The problem, I think, that CDCR, and is becoming more recognized, is the parole outpatient system does not provide the full range of intensive services that are needed for the highest risk parolees. That's why CDCR is attempting to develop services via counties and contract agencies to provide that full service partnership, that intensive level of care.

Judge Karlton: I'm not sure you've answered the question. The question was about 10,000 people are being released of which about 20-plus percent are Coleman class members. Does the community today prioritize in favor of those people as against population in general?

[2537] The Witness: thank you, your honor. The answer is generally, no, not the public mental health system.

By Mr. Galvan

Q And you are aware that other states, including Texas and Pennsylvania, have used population caps to reduce their prison populations, aren't you?

A I just missed say that again, a little more slowly.

Q You are aware that other states, including Texas and Pennsylvania, have used population caps to reduce their prison population, aren't you?

A I not specifically aware of what Pennsylvania did. I do know that other states have used population caps, yes.

Q In your study for preparing for your testimony today, you didn't find any evidence, did you, that Pennsylvania, Texas, or any other state stopped serving children in its community mental health system because of the population reductions?

A I'm having trouble with that question. I did not delve into, nor have I seen I have not seen the Pennsylvania research. Perhaps I should have. But I haven't—I'm really grounding my testimony on what I know is currently available in California's public mental health system, and the capacity around that, and the undercapacity to serve adequately, as evidenced by recidivism rates in the parole outpatient system.

Q As you sit here today, you have no evidence that any other state that has reduced its prison population through a cap has

* * * *

[2546] By Mr. Galvan

Q The mental health directors association is a registered lobbying association; is that right?

A Yes, it is.

Q When you were asking for help, you specifically asked for help from three people, correct? Don Kingdon is one of them?

A Yes.

Q He's the assistant director of the association?

A Yes.

Q And Nancy Pena, P-E-N-A, is another?

A Pena? She is a mental health director in California.

Q You asked for her help?

A I asked to discuss an issue on *valdivia* with them.

Q And Patricia Ryan, the executive director, you asked her for help?

A I asked to have a conversation.

Mr. Galvan: could we look at bat 551, Mr. Jones, which is going to be marked as pa 43?

(Document displayed.)

By Mr. Galvan

Q You asked her for help in an e-mail on or about August 21st; is that right?

A I don't remember the date, but that could easily be correct.

Q If we could zoom in on the middle portion, original message, under "thanks, pat"? Down to the very bottom there.

[2547] Do you recall sending a message with that subject line, "really would like brief time to talk re: Coleman issues"?

A Yes, I do.

Q Your question to them, and I'll just read it into the record was:

> "Hi, Pat and Don. As I get deeper into assertions related to the Coleman suit, I anticipate increased pressures and questions about the role and responsibility of county public mental health

> systems to serve parolees. I have to do responses to several plaintiffs' expert witness reports by the end of Wednesday August 27 and would like a chance to discuss some of these issues with you, especially our position that county mental health is not responsible for treatment of individuals who are on active parole status, aside from the prohibition under MHSA. I think I will be challenged on this and will need to identify code citations, history, et cetera, and this is in light of continued, although perhaps weakening, assertions from CDCR about our responsibility to treat all of our residents." When you were asking for help with "our position,"

Were you asking for that help–was "our position" the mental [2548] health director's association or your position as CDCR's expert in this case?

A I was attempting to get clarification as to the

Historical–when I said there have been historically two parallel systems, the adult outpatient parole system and the public mental health system, what I was attempting to get was clarification about the consistency across California, frankly, that public mental health systems generally have not accepted active parolees into the public mental health system, other than for crisis psychiatric emergency care, and so that's the, quote, position I was referring to.

Q And—

A That's really historical practice.

Q You were asking them for some code citations. Did you find any code citations?

A there are—no, it's really practice and not code citations.

Q So as you sit here today, you still don't know of any authority in the law for county mental health directors to deny service to parolees, do you?

A To my knowledge, there is not legal authority. There is historical precedent and practice.

Judge Karlton: there's also historical—never mind. Go ahead.

[2549] By Mr. Galvan

Q And you are aware, aren't you, that there has been testimony in this trial that parolees, thousands of them, are returned to prison each year because they can't get access to mental health services in the community?

A I have not heard the testimony for the trial, but I would not be surprised at that being testimony.

Q so you wouldn't be surprised if it were true that thousands of parolees are returned to prison each year because they cannot access care in the community?

A My understanding is that there is certainly a factor in returning that has to do with lack of access to treatment, both substance abuse and mental health treatment. Mental health–and I would remind you there are many people in California that are seriously mentally ill that do not have access to adequate treatment, including people involved in the criminal justice system.

Q And you've said in your reports that under the realignment statute, your county mental health obligation is to provide services to the extent resources are available, correct?

A Yes, I did. I did.

Q And resources are limited, correct?

A resources are probably about 50 percent of what the need is.

Q Okay. When resources are limited you employ triage to decide where to use your resources, right?

[2550] A Yes, that is what systems do.

Q And one element of your triage system is to ask whether the patient has other resources to get care, correct?

A Yes.

Q For example, if a patient has private insurance, you might not serve them directly, but help link them up with their insurance; is that right?

A Yes, absolutely.

Q And when a parolee comes in for service and participates in your–in county mental health triage, one of the decisions made is that that person has another resource for service, correct?

A Yes, yes.

Q And that resource for service is the parole outpatient clinic, correct?

A Right. As I said, practice has been that generally people who are on parole are–go to the parole outpatient system. They don't generally come, with some exceptions, to the public mental health system while they were on parole.

Q If a parolee comes to the mental health system or community mental health system, and they need something beyond POC care, they need some kind crisis care, you still have to triage them, right?

A If an individual requires psychiatric emergency services, yes, you have to triage anyone who comes in.

[2551] Q And if after the psychiatric emergency services, they need continued high level services, does county mental health continue to serve them?

A I would answer that the practice has typically been that, no, and let me clarify one piece. The—currently, in California, the most intensive level of care, which is the full-service partnerships, are funded through the mental health services act, and that specifically precludes parolees, so that there really isn't capacity in terms of the funding that is available for those most intensive services to serve parolees.

Q So, therefore, a mental health director who felt he had to prioritize released prisoners would not have the option of prioritizing them for services funded by the mental health services act, correct?

A Not, no.

Q He would have to continue serving the general public, correct?

A Yes, yes, of whom there are more than—more people than services are available.

Q And isn't it correct, to your knowledge, that the mental health services act funding constitutes about 1.5 billion out of over $5 billion in the community mental health budget?

A That sounds correct, yes.

Q Isn't it your understanding that about 3.8 billion comes from the realignment funds; isn't that correct?

* * * *

[2594] you are asking?

Q. uh-huh.

A. I would say the correct answer, no one knows. Again, if you base it on the research of the rand corporation, the vast majority of people that come to prison commit very few crimes before coming to prison, and a small number have committed a lot of crimes.

But that study has been reviewed with some skepticism by a number of scholars, but that's basically what that research shows; that most prisoners commit very few crimes per year.

Q Let's talk about some specific crimes. The rand study, you agree, indicated that in California the—those who commit robbery have an annual offense rate of 50, right? Fifty robberies. Burglary has an annual offense rate of 102.

A. Again, let me restate—you are taking the average, okay. And the national academy of sciences did a reanalysis of that data.

And rand corporation agrees with this analysis; that most of the prisoners are doing—the prisoners said they had committed no crimes, one or two or three crimes.

Then they had these people out there saying they were committing hundreds of crimes a year based on self-report surveys to interviews at the reception centers.

That's how this was done. It's self-report by prisoners to researchers. And they get this incredibly skewed [2595] reaction or result, which is that five or ten percent say they are committing runs hundreds of crimes a year, but the vast majority is saying they are doing none, one, two or three.

So when you give that 50, you know, that's a statistical thing you are doing, which is suggesting they are all doing 50 to 100 crimes. No, it's just the opposite. The vast majority are involved only in episodic crimes.

The rand corporation concluded that you could lower prison populations across the country by just focusing on those high end career criminals. And that was their original proposal.

They then in a subsequent study found they couldn't do that because the people they thought that were committing 50 to 100, 200 crimes per year, in fact, when released did not. And they recanted their findings and said the career criminal cannot be predicted based on their research methods.

Judge Karlton: sir, we have heard from two law enforcement folks numbers like 12 crimes are committed before anybody is arrested. Is there, as far as you know, any research that supports that assertion?

The Witness: No.

Judge Karlton: Okay.

The Witness: Okay.

Ms. Barlow: Could we put up—

Judge Reinhardt: Are all those figures, the high [2596] ones and the low ones, based on what the people on their way to prison say they did?

The Witness: They are based exclusively on an interview that literally was done with rand and Dejulio did. They interviewed prisoners coming to the reception centers and they asked them in the last 18 months how many of these following crimes did you commit.

Judge Reinhardt: And then you say when they were released, they didn't commit crimes, at least that we know about. What about the two, two to three? The ones who said, I only committed one or two crimes. Is there any data as to what they did when they got out?

I mean, is there any reason to believe their statements are any more reliable than the ones who said I committed 50 crimes?

The Witness: They did not find that there was a correlation between what they thought were high and low based on the self-report data.

Judge Reinhardt: In other words, all of this is pretty worthless.

The Witness: Some have reached that conclusion, Your Honor.

Judge Karlton: Do you have an opinion as to whether it is of any use at all?

The Witness: My opinion is it's not. And it's also [2597] The opinion of other scholars who have done reanalysis of the data.

Ms. Barlow: If we could put up the exhibit? This Is—

Ms. Evenson: Is this an exhibit, counsel?

Ms. Barlow: It is an exhibit, yes.

Ms. Evenson: What exhibit is it?

Ms. Barlow: It is–let's see. It's di-6–shoot. I don't seem to have the reference right here.

Ms. Evenson: What is the name of the document?

Ms. Barlow: This is from "making confinement Decisions."

A. Is that from Mr. Zedlewski?

By Ms. Barlow:

Q. Ed Zedlewski, national institute of justice. You are familiar with that, right?

A. Very familiar with it.

Ms. Barlow: if you could put table 1 up on the Screen?

Judge Karlton: Well, there seems to be some doubt as to whether it's—

Ms. Barlow: it is an exhibit, your honor. It hasn't been admitted yet, but it is—

Judge Karlton: well, nothing has been admitted. We still have to go through that yet. Counsel wants to know what

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[Pages 2719-2866] VOL 14

UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND FOR THE NORTHERN DISTRICT OF
CALIFORNIA UNITED STATES DISTRICT COURT
COMPOSED OF THREE JUDGES PURSUANT TO
SECTION 2284, TITLE 28 UNITED STATES CODE
[Filed: 12/22/2008]

No. CIV S-90-0520
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
Friday, December 19, 2008

(Appearances on following pages)

Reported by: Joan Marie Columbini, CSR 5435, RPR
Debra L. Pas, CSR 11916 CRR, RMR, RPR
Official court reporters, U.S. District court

[2857] Judge Karlton: Of course, of course. Goes without Saying.

Mr. Bien: We will get everything in.

Judge Karlton: whatever you need. Between now and the findings—proposed findings of fact whatever you guys need, just send us a note and saying, we have all agreed that it's Wednesday, that it's Friday, that it's two weeks from Tuesday. That's fine.

Ms. Barlow: Perfect. Thank you, your honor.

Judge Reinhardt: One other thing to keep in mind in preparing whatever you are preparing. This case has been tried on the assumptions by the defense that the burden or whatever happened with any kind of potential release order would be the amount of prisoners requested by the plaintiffs. So all the testimony has been what would the effect be of granting plaintiffs' full relief.

It's possible that some of the defense might want to give us their ideas at least about if there were an order, what should the number be and what would the effect of that be, rather than just limiting yourself to the idea that that prisoner release order would grant plaintiffs full relief.

Judge Karlton: And I'm concerned, just one of the thousands of things that I'm concerned about, the 130 number, 130 percent is contrary to everybody's testimony as to what you need, which is 95 percent.

[Pages 2867-3098] VOL 15

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 02/12/2009]

No. CIV S-90-0520 LKK JFM
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
Plaintiffs,
v.
ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings
San Francisco, California
February 3, 2009

(Appearances on following pages)

Reported by: Debra L. Pas, CSR 11916 CRR, RMR, RPR
Official reporters- U.S. District Court
Computerized Transcription by Eclipse

* * * *

[2953] Increased substantial risk to the health and safety of CDCR staff, inmates and the public.

Mr. Mello: that's what the emergency proclamation says.

Judge Karlton: No.

Judge Reinhardt: So you acknowledge that the overcrowding is a cause?

Mr. Mello: Correct.

Judge Reinhardt: And your only disagreement is it's not the primary cause?

Mr. Mello: Correct. I mean, that statement is in evidence. They moved for it into evidence before. We are not disputing the emergency proclamation and what it says.

What we are disputing is whether plaintiffs met their burden under the PLRA.

Judge Reinhardt: Showing that it's the primary cause?

Mr. Mello: Correct. And that a prisoner release order is the only fix.

Judge Karlton: That's a separate question.

Judge Reinhardt: That's a separate issue. We only get to the prisoner release order if it's the primary cause.

Mr. Mello: Of course.

Judge Reinhardt: So the issue, as far as you're concerned, is that it is a cause of the health problems in the [2954] prisons.

Mr. Mello: we've never disputed that overcrowding—

Judge Reinhardt: And your only issue is whether it's a primary cause as opposed to a cause?

Mr. Mello: Yes.

Judge Reinhardt: And the governor's position is that it's a cause, not a primary cause.

Mr. Mello: Well, the governor's position is spelled out in the emergency proclamation.

Judge Reinhardt: No, our current governor, at this point.

Mr. Mello: At this point—well, let me back up. The emergency proclamation was signed in 2006. It was based upon current conditions.

Judge Karlton: Right. It's worse now. There are more prisoners.

Mr. Mello: I don't believe that's true. I believe that defies the record in this case, that it's worse now.

Judge Karlton: No, sir. At the time that the Governor announced the proclamation, there were 166,148 prisoners. There are more now. Is that right?

Mr. Mello: There may be more prisoners under the care of CDCR. However, the question is how many prisoners? Because we are focused on the 33 adult institutions in state, how many prisoners are now in adult institutions?

* * * *

[2960] Mr. Mello: Okay. Even if that's what I think, I think I'm now speaking to the second prong of the first clear and convincing standard.

Judge Karlton: Let's take the first prong. Do you agree or disagree—it's very difficult because I don't know who you represent.

But if you agree—do you agree or disagree that the question of primary care does not mean—primary cause does not mean that finding overcrowding and reducing overcrowding would end the issue; that is, that there would continue to be other causes which have to be addressed as well?

Mr. Mello: I think with respect to primary cause, whether it's the primary cause or not, my belief, and I believe it was in our motion in limine, that primary cause means just the biggest cause. I'm not saying it has to be the only case.

Judge Karlton: Okay. So that if it turns out that, yes, we find it's a primary cause, yes, we find that it will not in itself cure the constitutional defect, we nonetheless have not only the power, but the obligation to set a cap. Is that right?

Mr. Mello: I disagree.

Judge Karlton: That's what I'm asking.

Mr. Mello: I believe that if this court finds, which I think it must and as Mr. Bien admitted up here a few moments ago, that it won't remedy the constitutional violation, then it

* * * *

[2984] '09-'10. I don't know what you're referring to.

If you are referring to the most recent one that we submitted briefing on, I believe our position is clear. And it says, here is the budget proposal. It doesn't propose the release of prisoners, the savings that we are being forced to try to have with respect to parole.

Judge Karlton: so you are prepared to say that the governor is proposing to the State that we endanger public safety.

Mr. Mello: no, I'm not.

Judge Reinhardt: so you will agree that whatever the Governor proposed would not endanger public safety?

Mr. Mello: However motivated.

Judge Reinhardt: Are you willing to say that whatever the governor proposed would not endanger the public safety?

Mr. Mello: I am sure that the governor did not make the proposal that he thought would endanger public safety. That being said—

Judge Reinhardt: Okay. So we can proceed from there, is whatever his proposal was.

Mr. Mello: We can presume that it was a proposal that would be different in the main revise, that isn't acted upon unless approved by the legislature.

Judge Reinhardt: I know. Sometimes the governor, as [2985] you said before, would like the court to do what they aren't able to do themselves. That's all clear. It doesn't matter.

We are trying to find out–I don't know who the state is, but the governor is the defendant in this case and you are the governor's lawyer, I assume.

Judge Karlton: Apparently.

Judge Reinhardt: And I assume you were going to take the same position that the governor is taking. And the governor, as I understand it, has told the legislature and the public that certain actions will not endanger the public safety.

Mr. Mello: I don't believe the–well, I believe I have answered your question. I don't believe the governor would propose something that he thought would endanger public safety. So I believe I have answered that question.

Judge Reinhardt: What is the governor's proposal? How many people would—you know what a prisoner release order is. I'm not saying he said open the gate to the prisons. I'm saying, how many people?

Mr. Mello: Your Honors, we submitted briefing regarding the budget proposal. It says what it says. It says that the savings are going to be achieved primarily by reducing the number of individuals who are on parole supervision. That's what it says. It doesn't say release prisoners.

Judge Reinhardt: I know that. I just said it

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[Pages 3099-3148] VOL 16

UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT OF CALIFORNIA AND FOR THE NORTHERN DISTRICT OF CALIFORNIA UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

[Filed: 02/12/2009]

No. CIV S-90-0520 LKK JFM
THREE-JUDGE COURT

RALPH COLEMAN, *et al.*,
Plaintiffs,
v.
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No. C 01-1351 TEH

MARCIANO PLATA, *et al.*,
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ARNOLD SCHWARZENEGGER, *et al.*,
Defendants.

Transcript of proceedings

San Francisco, California
February, 4 2009

(Appearances on following pages)

Reported by: *Debra L. Pas, CSR 11916 CRR, RMR, RPR*
Official reporters- U.S. District Court
Computerized Transcription by Eclipse

* * * *

[3137] Safety matter?

Mr. Specter: as a public safety matter and as a practical matter.

In fact, some of the testimony you heard said some of these plans could be developed in a few months, period. And then implementing them would be done over two years.

We weren't giving you a number. You know, if we wanted a—we weren't planning—we weren't negotiating. I mean, we weren't giving you a lone—we try to be reasonable and give you a fair number right now, not an unrealistic number.

And, finally, there is no evidence to the contrary that it can't be done safely in two years.

In terms of the 130 percent issue, we agree with your comments yesterday that it's not an exact science. But what it is, is a consensus among experts that we've used and, as Mr. Bien said, Jeanne Woodford, who ran the prison system and who worked there 28 years, thinks it's a reasonable number and will get us to where we want to go. It seems to me that's a pretty reliable piece of evidence upon which to base a decision.

Secondly, you know, there is no other number out there. The state had the opportunity, as you asked them to do several times, to come up with a number and they didn't. And Mr. Cate testified that they wanted to reduce the population, but he didn't even have a number in mind in which he wanted to [3138] reduce it to.

So the short answer is the state doesn't know how much they want to reduce it to and they don't want, apparently, to present any evidence about what another number should be.

So I think that we have satisfied our burden on that issue, and that there is no contrary evidence.

Secondly, this is an injunction. It's not a monetary judgment. And as Judge Henderson and Judge Karlton knows, injunctions are kind of living documents. They are subject to modification—

Judge Reinhardt: Like the Constitution.

Mr. Specter: Except it's not quite so hard to amend. Judge Karlton: all you need is five members of the Court.

Mr. Specter: So if it turns out that this number—it's our best estimate based on the evidence. If it turns out this number is not the best number, based on changed circumstances or how things develop, it can be modified over time. And we—

Judge Karlton: That's a very important issue for us. In the underlying cases there is a single Judge doing what Judges do. What we are doing here is extraordinary.

And let me assure you, you know, Judge Reinhardt doesn't want to come back every three months, or at all.

And that is, I find, troubling. If it were my order,

* * *

APPELLANT'S
BRIEF

AUG 27 2010

OFFICE OF THE CLERK

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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August 27, 2010

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QUESTIONS PRESENTED

1 Whether the three-judge district court had jurisdiction to issue a "prisoner release order" pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626.

2. Whether the court below properly interpreted and applied Section 3626(a)(3)(E), which requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right, and ... no other relief will remedy the violation of the Federal right" before issuing a "prisoner release order."

3. Whether the three-judge court's "prisoner release order," which was entered to address the allegedly unconstitutional delivery of medical and mental-health care to two classes of California inmates, but mandates a system-wide population cap within two years that will require a population reduction of approximately 46,000 inmates, satisfies the PLRA's nexus and heightened narrow tailoring requirements while giving sufficient weight to potential adverse effects on public safety and the State's operation of its criminal justice system.

PARTIES TO THE PROCEEDING

Appellees are the following:

Gilbert Aviles
Steven Bautista
Ralph Coleman
Paul Decasas
Raymond Johns
Joseph Long
Clifford Myelle
Marciano Plata
Leslie Rhoades
Otis Shaw
Ray Stoderd

Intervenor-plaintiff:

California Correctional Peace Officers' Association,

Appellants are the following five defendants

Governor Arnold Schwarzenegger
Matthew Cate, Secretary of the California Department of Corrections and Rehabilitation
John Chiang, California State Controller
Ana J. Matosantos, Director of the California Department of Finance
Stephen W. Mayberg, Director of the Department of Mental Health

The following 144 individuals are intervenor-defendants

Samuel Aanestad, Legislator
Anthony Adams, Legislator
Amador County Sheriff Martin Ryan
Joel Anderson, Legislator
Roy Ashburn, Legislator
Chief Probation Officer Kim Barrett

James F Battin, Jr.*, Legislator
Tom Berryhill, Legislator
Sam Blakeslee, Legislator
Police Chief Michael Billdt
Butte County Chief Probation Officer John Wardell
Butte County Sheriff-Coroner Perry L. Reniff
Calaveras County Sheriff Dennis Downum
District Attorney Ronald L. Calhoun
Chief Probation Officer Lionel Chatman
City of Alhambra Police Chief Jim Hudson
City of Atwater Police Chief Richard Hawthorne
City of Delano Chief of Corrections George Galaza
City of Delano Police Chief Mark DeRosia
City of Fremont Police Chief Craig Steckler
City of Fresno Police Chief Jerry Dyer
City of Grover Beach Police Chief Jim Copsey
City of Modesto Police Chief Roy Wasden
City of Pasadena Police Chief Barney Melekian
City of Paso Robles Police Chief Lisa Solomon
City of Roseville Police Chief Joel Neves
City of San Bernardino Police Chief Michael Billdt
City of Santa Clara Police Chief Steve Lodge
City of Sonora Police Chief Mace McIntosh
City of Vacaville Police Chief Rich Word
City of Whittier Police Chief Dave Singer

City of Woodland Police Chief Carey Sullivan
District Attorney Gregg Cohen
Contra Costa County Chief Probation Officer Lionel Chatman
Contra Costa County Sheriff Warren Rupf
County of San Mateo
County of Santa Barbara
County of Santa Clara
County of Solano
County of Sonoma
Paul Cook, Legislator
Dave Cox, Legislator
Police Chief Mark DeRosia
Chuck DeVore, Legislator
Del Norte County Sheriff Dean Wilson
Sutter County Sheriff Jim Denney
District Attorney Bonnie M. Dumanis
Robert Dutton, Legislator
Michael D. Duvall, Legislator
El Dorado County Sheriff Jeff Neves
Bill Emmerson, Legislator
District Attorney Bradford Fenocchio
Fresno County Chief Probation Officer Linda Penner
Fresno County Sheriff Margaret Mims
Jean Fuller, Legislator
Glenn County Sheriff Larry Jones
National City Police Chief Adolfo Gonzales
Ted Gaines, Legislator
Martin Garrick, Legislator
Police Chief Richard Hawthorne
Sheriff Pat Hedges
Dennis Hollingsworth, Legislator
Shirley Horton*, Legislator
Guy S. Houston*, Legislator
Police Chief Jim Hudson
Bob Huff, Legislator
Humboldt County Sheriff Gary Philip

Inyo County Chief
Probation Officer
Jim Moffet
Inyo County Sheriff
William Lutze
District Attorney
Edward R. Jagels
Kevin Jeffries,
Legislator
Sheriff Larry Jones
Rick Keene*,
Legislator
Kern County Sheriff
Donny Youngblood
District Attorney
Robert Kochly
Doug La Malfa*,
Legislator
Bill Maze*, Legislator
Lake County Sheriff
Rod Mitchell
Lassen County
Sheriff Steve
Warren
Los Angeles County
Sheriff Lee Baca
Sheriff William Lutz
Abel Maldonado,
Legislator
Mariposa County
Chief Probation
Officer Gail Neal
Sheriff Jim Mele
Police Chief Barney
Melekian
Mendocino County
Sheriff Tom Allman
Merced County
Sheriff Mark Pazin
Chief Probation
Officer Don Meyer
Chief Probation
Officer Jim Moffett
Mono County Sheriff
Richard Scholl
Monterey County
Sheriff Mike
Kanalakis
San Joaquin County
Sheriff Steve Moore
District Attorney
Clifford Newell
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District Attorney
David W. Paulson
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Placer County Sheriff
Edward N. Bonner
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John R Poyner
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Tony Rackauckas
District Attorney
Michael Ramos

District Attorney Michael Ramsey
Chief Probation Officer Brian Richart
District Attorney Todd Riebe
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George Runner, Legislator
Sharon Runner*, Legislator
San Benito County Sheriff Curtis Hill
San Diego County Sheriff William B. Kolender
San Mateo County Sheriff Greg Munks
Santa Barbara County Chief Probation Officer Patricia Stewart
Santa Barbara County Sheriff Bill Brown
Santa Clara County Sheriff Laurie Smith
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District Attorney Donald Segerstrom
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District Attorney Gerald T. Shea
Solano County Chief Probation Officer Isabelle Voit
Solano County Sheriff Gary R. Stanton
Jim Silva, Legislator
Cameron Smyth, Legislator
Police Chief Lisa Solomon
Sonoma County Chief Probation Officer Robert Ochs
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Sonoma County Sheriff/Coroner William Cogbill
Todd Spitzer*, Legislator
Stanislaus County Chief Probation Officer Jerry Powers
Stanislaus County Sheriff Adam Christianson

Stanislaus County Sheriff's Department
District Attorney Christie Stanley
Chief Probation Officer Karen Staples
Audra Strickland, Legislator
District Attorney Gregory Totten
Van Tran, Legislator
Tehema County Sheriff Clay Parker
Ventura County Sheriff Bob Brooks
Michael N. Villines, Legislator
Mimi Walters, Legislator
Police Chief Rich Word
Mark Wyland, Legislator
Yolo County Sheriff Ed Prieto
Yuba County Sheriff Steve Durfor
Bill Berryhill, Legislator
Connie Conway, Legislator
Danny Gilmore, Legislator
Curt Hagman, Legislator
Diane Harkey, Legislator
Steven Knight, Legislator
Dan Logue, Legislator
Jeff Miller, Legislator
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* No longer in the Legislature

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OPINIONS BELOW

Although the courts below have issued many opinions, appellants ("the State") note here only those containing the judgment and rulings essential to resolving the questions presented. On January 12, 2010, the three-judge district court entered the "Order to Reduce Prison Population" (JS2-App. 1a-10a[1]) now on appeal. See 2010 WL 99000. On August 4, 2009, the three-judge court made the predicate findings for that order. See 2009 WL 2430820 (JS1-App. 1a-256a) Orders granting plaintiffs' motions to convene three-judge proceedings (JS1-App. 273a-304a) are available at 2007 WL 2122657 and 2007 WL 2122636.

JURISDICTION

On July 23, 2007, over the State's objections, the District Courts for the Northern and Eastern Districts of California entered orders convening a three-judge district court pursuant to the PLRA, 18 U.S C § 3626(a)(3)(B), in accordance with 28 U.S.C. § 2284. JS1-App. 273a-304a. As shown *infra* § I, the three-judge court was improperly convened and therefore lacked jurisdiction to issue the judgment.

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[1] The Clerk previously authorized the parties to use the appendices filed in Number 09-416 Appellants cite their Appendix from that case as "JS1-App " and the Appendix to the Jurisdictional Statement in this case as "JS2-App " The records in *Plata*, No C01-1351-TEH (N D Cal), and *Coleman*, No CIV-S-90-0520-LKK (E D Cal), are cited by docket entry number (*i e* , "*Plata* D E __," "*Coleman* D E __") in the Rule 33 2 version of this brief, as well as in the booklet version when the cited materials are not included in the deferred joint appendix In the Rule 33.2 version of this brief, trial transcripts are cited as "Tr " and trial exhibits are cited by party and number, *i.e* "Defs' Trial Ex __ "

The three-judge court's "Order to Reduce Prison Population" granted injunctive relief under the PLRA. JS2-App. 1a-10a. The State timely appealed and filed its jurisdictional statement This Court granted review but postponed consideration of jurisdiction. Pursuant to 28 U.S.C. § 1253, this Court has jurisdiction (i) to determine whether the three-judge court lacked jurisdiction, and, (ii) to review the judgment should this Court find that the three-judge court had jurisdiction.

STATUTORY PROVISIONS INVOLVED

The PLRA's relevant provisions, 18 U.S.C. § 3626, are reproduced at JS2-App. 71a-73a and in this brief's statutory addendum.

STATEMENT OF THE CASE

Congress enacted the PLRA to cabin the federal courts' role in prisoners' rights cases. See *Jones* v. *Bock*, 549 U.S. 199, 202-04 (2007). The Act restricts the availability and scope of prospective relief. 18 U S.C. § 3626(a)(1)(A); *Nelson* v. *Campbell*, 541 U S. 637, 650 (2004). Congress specially sought to curtail the use of prisoner release orders, making them the remedy of "'last resort'" for violations of prisoners' federal rights. JS1-App. 73a. Only three-judge district courts can order prisoner release, and they may not be convened to consider such relief unless the remedial orders entered by a single-judge district court have been given a "reasonable amount of time" to remedy the alleged violations. 18 U.S.C. § 3626(a)(3)(A). A three-judge court cannot order prisoner release unless "crowding" is the "primary cause" of the federal violation and "no other relief will remedy the violation." *Id.* § 3626(a)(3)(E).

During remedial proceedings involving the Eighth Amendment rights of two plaintiff-classes, the three-judge court was convened and issued a prisoner release order in contravention of the PLRA's text and purpose. The single-judge district courts erred by convening three-judge proceedings because the State had not been given a reasonable amount of time to comply with significant remedial orders that had then-recently been issued, including orders compelling the State to effectuate the plans of the Receiver who had taken control of the California Department of Corrections and Rehabilitation's ("CDCR") healthcare system, as well as recent revisions to the Special Master's plans for improving mental-health care.

The three-judge court then issued its Order to Reduce Prison Population. That "prisoner release order" requires the State to cap its prison population at 137.5% of the institutions' combined design capacity as a remedy for alleged Eighth Amendment violations sustained by two discrete plaintiff-classes. The State must reduce its overall prison population by between 38,000-46,000 inmates within two years. The court ordered this massive release despite, *inter alia*, the Receiver's confirmation that care satisfying the Eighth Amendment can be provided notwithstanding prison overcrowding and appellees' experts' concurrence in that view and recognition that a prisoner release order would not extinguish the alleged federal violations. The court refused to consider current conditions in the prisons at the time of trial, let alone more than one year later when it issued judgment. Moreover, the court based its release order solely on professional goals for limiting prison overcrowding, not any determination of the "least intrusive means necessary" to remedy the plaintiff-classes' *Eighth Amendment* rights. 18 U.S.C. § 3626(a)(1)(A) The court also failed to accord substantial weight to the adverse impact of its order on public safety. *Id.* This Court should reverse the judgment.

A. Statutory Background

The PLRA, Pub. L. No. 104-134, tit. VIII, 110 Stat. 1321, 1321-66 (1996), carefully circumscribes the federal courts' remedial powers over conditions of confinement. 18 U S.C § 3626. Any prospective relief must be "narrowly drawn, extend[] no further than necessary to correct the violation of the Federal right, and [be] the least intrusive means necessary." *Id* § 3626(a)(1)(A). In considering injunctive relief, a court "shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief" *Id.*

Congress imposed additional and more intrusive limits on a federal court's ability to enter a "prisoner release order" as a prospective remedy. *Id.* § 3626(a)(3); see also *id.* § 3626(g)(4) ("prisoner release order" is "any order . that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or non-admission of prisoners to a prison"). Only a three-judge district court may issue such orders *Id.* § 3626(a)(3)(C). A three-judge court cannot be convened:

> unless—(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and (ii) the defendant has had a

> reasonable amount of time to comply with the previous court orders.

Id. § 3626(a)(3)(A). If properly convened, a three-judge court "shall enter a prisoner release order only if the court finds by clear and convincing evidence that—(i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation of the Federal right." *Id.* § 3626(a)(3)(E).

B. Factual Background

1. The appeal involves two class actions, *Plata* v. *Schwarzenegger* and *Coleman* v. *Schwarzenegger*, concerning healthcare conditions previously determined to violate the Eighth Amendment. *Plata* implicates the healthcare provided to adult inmates with "serious medical conditions," and *Coleman* involves mental-health care provided to inmates with serious mental disorders. Each case has been in its remedial stage for years.

In *Plata*, Judge Henderson approved a stipulation for injunctive relief in 2002 requiring the State "'to provide only the minimum level of medical care required under the Eighth Amendment.'" JS1-App. 16a. In October 2005, the court concluded that the State was not satisfying its obligations under that decree. *Id.* at 14a It therefore placed CDCR's medical care system into Receivership. *Id.* The court concluded that "'despite the best efforts of [the State],'" *id.* at 22a, Eighth Amendment violations persisted for numerous interrelated reasons, but overcrowding was not listed as one of them. *Id.* at 27a-28a (*e.g.*, CDCR had "serious personnel problems," "was incapable of recruiting qualified personnel," "lacked medical leadership," had not implemented necessary systems for tracking inmates, and had "'a culture of non-accountability and non-professionalism'").

The court recognized that imposing the Receivership was "'a drastic measure,'" but found that "'establish[ing] [it], along with those actions necessary to effectuate it[]'" were the "'least intrusive means'" to remedy the Eighth Amendment violations. JS1-App. 28a; *id.* at 30a (granting the Receiver "'all powers vested by law in the Secretary of CDCR'"). The Receiver's appointment was effective on April 17, 2006. *Id.* at 29a-30a. Thereafter, the Receiver began gathering information necessary to formulate a plan to provide care that would satisfy the Eighth Amendment. On November 13, 2006, on the same day that the Receiver filed a motion for an extension to submit a plan of action to the court, the *Plata* appellees moved to convene a three-judge court to consider a "prisoner release order." *Id.* at 275a. The Receiver subsequently was granted the extension; he filed a proposed plan on May 10, 2007 and a final plan on November 15, 2007. JA 1071-99; *Plata* D.E. 658, 928, 930; see JS1-App. 280a.

In *Coleman*, following a 1994 trial, the court concluded that the mental-health care provided to the class violated the Eighth Amendment. JS1-App. 31a, 33a-35a. In December 1995, the court appointed a special master to oversee injunctive relief. *Id.* at 36a. In 1997, the court approved plans developed by the Special Master; and in the following years, "defendants continued to work with the Special Master to implement and revise" those plans. *Id.* at 37a. In March 2006, the court approved a revised "Program Guide" of remedial plans, policies and procedures aimed at achieving constitutional care. *Id.* at 37a-38a. Eight months later, plaintiffs moved to convene a three-judge court. *Id.* at 304a.

2. On July 23, 2007 (almost four months before the Receiver's final plan was issued in *Plata*), both single-judge courts granted plaintiffs' motions to convene a three-judge court over the State's objections. See JS1-App. 273a-304a.[2] Judges Henderson and Karlton recommended that both cases be heard by the same three-judge court. *Id.* at 286a, 304a. Then-Chief Judge Schroeder assented, seating Judge Reinhardt to complete the panel. JA 491; see 28 U.S.C. § 2284. After three-judge proceedings commenced, the State remained obligated to effectuate the Receiver's and the Special Master's plans. See, *e.g.*, JS1-App. 287a; see also *id.* at 30a (*Plata* court appointed a new Receiver in January 2008; he issued a Turnaround Plan of Action in June 2008, JA 1117-78, which the State continues to implement).

A trial on prisoner release was held between November 2008 and February 2009. The court prohibited defendants from introducing evidence concerning whether the Eighth Amendment violations were "'current and ongoing,'" JS1-App. 78a n.42, and concerning prison conditions after August 30, 2008, JA 1190 ¶ 2.e. The court also barred the State from obtaining discovery from or calling the Receiver or the Special Master to testify. See *Coleman* v. *Schwarzenegger*, No. CIV-S-90-520, 2007 WL 4276554, at *1 (E.D. Cal./N.D. Cal. Nov. 29, 2007); JA 1114-15, JA 1196-97.

On August 4, 2009, the court concluded that crowding was the "primary cause" of the alleged

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[2] The Ninth Circuit dismissed for lack of jurisdiction the State's appeals from the orders convening the three-judge court. *Coleman* v. *Schwarzenegger*, No. 07-16361, 2007 WL 2669591, at *1 (9th Cir. Sept. 11, 2007) (per curiam).

Eighth Amendment violations and that no other relief would remedy them. See JS1-App. 78a-168a, *id.* at 126a n.55. The order mandated that the State cap its system-wide prison population at 137.5% of the institutions' total "design capacity" within two years. *Id.* at 169a; see *id.* at 60a (156,352 inmates, *i e.*, 195.9% of design capacity, in August 2008) The required reduction would be approximately 46,000 inmates. *Id.* at 235a. The court concluded that its sweeping "prisoner release order" was appropriate notwithstanding that other causes for the alleged constitutional violations exist and that the population cap alone would *not* remedy the violations. *Id* at 134a, 143a. The court held that the cap satisfied § 3626(a)(1)(A)'s enhanced narrow tailoring requirements, see *id.* at 169a-185a, and, by not dictating how the cap should be implemented by the State, thereby gave substantial weight to any adverse impact on public safety and the operation of the criminal justice system. See *id.* at 185a-255a.

The court, however, recognized that the relief "extends further than the identified constitutional violations" and "is likely to affect inmates without medical conditions or serious mental illnesses." JS1-App 172a. It selected the 137 5% cap solely because it was "halfway between the cap requested by plaintiffs and [a group of] wardens' estimate [in 2004] of the California prison system's maximum operable capacity absent consideration of the need for medical and mental health care." *Id* at 184a The court recognized, however, that, absent effective rehabilitation programs, a prisoner release of this magnitude is likely to cause a statistically significant increase in crime *Id.* at 241a-248a.

3. The order required the State to submit, by September 18, 2009, a plan for meeting the 137 5%

cap within two years. JS1-App. 255a. The State timely appealed to this Court and unsuccessfully sought a stay. *Schwarzenegger* v. *Coleman*, 130 S Ct. 46 (2009). While preserving its challenges to the order, the State timely submitted a population reduction plan. JS1-App. 312a-353a. The State disclosed that even if proposals pending before the legislature were enacted, it could safely reduce the population to only 151% design capacity within two years. *Id.* at 317a-318a (plan would meet 137.5% within five years). The court rejected the plan and required the State to submit a plan that would rigidly comply with the 137.5% cap within two years JA 1525-33. Preserving its objections, the State submitted a revised plan to satisfy the 137 5% cap within two years, but could not ensure public safety JS2-App. 34a

On January 12, 2010, the "Order to Reduce Prison Population" approved the revised plan. JS2-App. 3a-6a. Without analyzing current conditions affecting the plaintiff-classes, the court reaffirmed that § 3626(a)(3)(E)'s requirements for a "prisoner release order" were satisfied, as were § 3626(a)(1)(A)'s rigorous narrow tailoring requirements. *Id* at 2a The court acknowledged that it had "not evaluated the public safety aspect of the State's proposed plan," but stated that "the evidence presented at trial demonstrated that means exist to reduce the prison population without a significant adverse impact on public safety or the criminal justice system " *Id.* at 3a-4a.

The order requires that within 24 months of taking effect, the State's systemwide prison population will be reduced to 137.5% design capacity JS2-App. 6a. *Sua sponte*, the court stayed the order pending disposition of this appeal *Id.* at 8a

On January 15, 2010, this Court dismissed the State's appeal of the August 4, 2009 order for lack of jurisdiction. *Schwarzenegger* v. *Plata*, 130 S. Ct. 1140, 1140 (2010). On January 19, 2010, the State timely appealed the "Order to Reduce Prison Population," and on June 14, 2010, this Court granted review but postponed consideration of jurisdiction.

SUMMARY OF ARGUMENT

Using the guise of providing healthcare that complies with the Eighth Amendment, the court below has accepted appellees' invitation to undertake comprehensive institutional reform directed at prison crowding. If it stands, the judgment will require the State to reduce its prison population by roughly 38,000 to 46,000 inmates within two years. As the district court recognized, the release of these inmates will jeopardize the safety of California residents unless substantial investments in rehabilitation programs for released inmates are made. There is, however, no guarantee that California, which remains mired in fiscal crisis, has the financial ability to offer those services, or that the political branches would agree to direct available funds to released prisoners rather than other pressing needs. In any event, it is clear that the PLRA does not require (or even permit) what the three-judge court has ordered here and therefore its judgment should be reversed

First, the judgment must be reversed because the three-judge court was improperly convened and thus lacked jurisdiction to issue any prisoner release order. Congress provided three-judge courts with exclusive jurisdiction to order release and forbid single-judge courts from convening three-judge proceedings until they had afforded defendants "a reasonable amount of time to comply" with all the "previous court orders" directed at remedying plaintiffs' federal rights. 18 U.S.C § 3626(a)(3) Here, however, the *Plata* and *Coleman* courts denied the State a reasonable opportunity to comply with remedies recently set in motion, including the implementation of the plans of a Receiver who was just taking control of CDCR's health care system. Doing so was utterly inconsistent with the prisoner release order's status as the remedy of last resort.

Second, if the three-judge court were properly convened, it committed reversible errors in holding that "crowding" is the "primary cause" of the alleged Eighth Amendment violations to the plaintiff-classes, and that "no other relief will remedy" those violations. *Id.* § 3626(a)(3)(E). The court below conducted no inquiry—either at trial or when it issued judgment approximately one year later—into current prison conditions, including the state of appellees' alleged Eighth Amendment violations. Contrary to the statute's prospective requirements, the court's conclusions were based solely on selective analyses of former conditions.

Independent of the flawed, limited inquiry, the court's § 3626(a)(3)(E) holdings are unsustainable. The court erroneously applied "primary cause" as if only "contributory cause" were required Having concluded that crowding was slowing other remedies for the alleged Eighth Amendment violations, the court found that crowding was both their primary cause and that no other relief would remedy the violations absent a release order. It did so despite the Receiver's statements that the State could "provide constitutional levels of care *no matter what the population is*," and plaintiffs' expert's testimony that fully effectuating the Receiver's plan alone would satisfy the Eighth Amendment.

Because the Receivership and other orders would remedy whatever Eighth Amendment violations to the plaintiff-classes persisted, and the record is plain that a release order alone will *not*, § 3626(a)(3)(E)'s requirements were not satisfied. The release order, as Judge Henderson acknowledged, "will not address the *core issue* in *Plata*, nor ... alleviate the reasons for the Receivership." JA 1861 (emphasis added). Instead, it was driven by the desire for institutional reform, which is precisely what the PLRA does not allow.

Finally, the system-wide 137 5% of design capacity cap must be reversed because it fails § 3626(a)(1)(A)'s strict narrow tailoring requirements. The cap has *no nexus* to alleged Eighth Amendment violations, current or otherwise Rather, plaintiffs sought a population reduction loosely based on the Federal Bureau of Prisons' goals for overcrowding, which are far more demanding than the Eighth Amendment Treating these aspirations as Eighth Amendment *minima* violates the PLRA Plaintiffs presented no evidence about what reduction was "necessary" to satisfy the Eighth Amendment, and admitted they lacked the information essential to making such a determination Instead, as their counsel acknowledged, they sought a cap that was "a reasonable number and will get us to where we want to go," JA 2563, and "could *improve* public safety and the administration of criminal justice systems throughout the state, *Plata* D E. 1766, at 7.

The court indulged plaintiffs' wishes, providing relief that not only is untethered to the Eighth Amendment, but is system-wide and expressly "extends further than the identified constitutional violations." JS1-App. 172a. The remedy thus violates the PLRA and this Court's holdings regarding the proper scope of federal systemic decrees, and invades the political branches' prerogative to manage their own affairs. Moreover, the court tacitly acknowledged that the ordered reduction would have an adverse effect on safety unless "the state were to divert [funds] to community corrections, rehabilitation, and re-entry resources." JS1-App. 232a. This, of course, the court below has no authority to require. Thus, the order does serious violence to the PLRA's requirement that the court "give substantial weight to any impact on public safety ... caused by [injunctive] relief."

ARGUMENT

I. THE THREE-JUDGE COURT LACKED JURISDICTION TO ENTER THE "PRISONER RELEASE ORDER."

The PLRA exclusively vests three-judge district courts with jurisdiction to order the release of prisoners—federal or state 18 U.S.C. § 3626(a)(3)(B). A district court shall not convene three-judge proceedings unless (i) "a court has previously entered an order for less intrusive relief" that failed to remedy the violation of federal rights, and (ii) "the defendant has had a reasonable amount of time to comply with the previous court orders." *Id.* § 3626(a)(3)(A); see *id.* § 3626(a)(3)(C), (D)

The *Plata* and *Coleman* courts mistakenly interpreted the PLRA to allow three-judge proceedings so long as the State had been given a reasonable amount of time to comply with *any* prior remedial order. Here, however, the State did not have a "reasonable amount of time to comply" with the legally relevant orders, thus the three-judge court was not properly convened. The three-judge court's judgment should be reversed for want of jurisdiction.

A. The *Plata* Court Erred In Granting Plaintiffs' Motion To Convene.

In convening three-judge proceedings, the *Plata* court erroneously held that it was not required to give the State a reasonable amount of time to comply with the recently appointed Receiver's plans to deliver constitutional care. See JS1-App. 280a. Shortly before convening three-judge proceedings, Judge Henderson had taken the "'drastic measure'" of placing CDCR's health care system in a receivership. JS1-App. 28a. The *Plata* court found that the "'Receivership, along with those actions necessary to effectuate its establishment'" were "'necessary'" and the "'least intrusive means to correct the[] violations'" of plaintiffs' Eighth Amendment rights *Id*

Although the Receiver's appointment was not effective until April 2006 and the Receiver had not issued his plan for remedying the alleged constitutional violations, plaintiffs moved to convene a three-judge court on November 13, 2006. JS1-App. 275a On July 23, 2007, the district court granted the motion, concluding that § 3626(a)(3)(A)(ii) was satisfied. *Id.* at 280a. It did so despite acknowledging that the Receiver had not commenced his duties until April 2006, had "only recently filed" his preliminary plan on May 10, 2007, and was not due to file a final plan of action for several months (a deadline extended to November 15, 2007) *Id.*[3] The court reasoned that it had given the State a reasonable amount of time to comply with orders from June 2002 and September 2004—orders wholly *unrelated* to the Receivership See *id.* at 279a. While acknowledging that the Receiver "has made much progress" in the brief time since his appointment, *id.* at 280a, the court held that it was not "require[d] .. to wait more time ... to see whether the Receiver's plans will succeed or fail," *id.* at 281a.

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[3] The May 2007 interim plan contemplated several years of efforts to remedy the claimed violations, and suggested that it "'w[ould] work'" without population control measures JS1-App 282a The Receiver found it "'simply wrong'" to think that

The court's analysis is wrong. Having established a Receivership which was implementing a plan to address alleged constitutional violations, the court was required to give the remedy of Receivership a "reasonable amount of time" to work before issuing a prisoner release order. The court's contrary holding violates § 3626(a)(3)(A)(ii), and the PLRA's requirement that "prisoner release" serves as the "'remedy of last resort '" JS1-App. 73a; see *Roberts* v. *Mahoning County*, 495 F. Supp. 2d 713, 715 (N.D. Ohio 2006) (per curiam) (three-judge court) ("a prisoner release order [must be] the only way to stop the unconstitutional behavior"); see also, *e.g.*, JA 1057-70, *Plata* D.E. 700, 647, 590, 554, 474 (orders effectuating Receivership).

1. The court's interpretation contravenes § 3626(a)(3)(A) by ignoring the variation between subparagraphs (i) and (ii) of that section. Subparagraph (i) requires only that the court previously have "entered *an* order" seeking to remedy the violation for which prisoner release is sought. 18 U.S.C. § 3626(a)(3)(A)(i) (emphasis added). In subparagraph (ii), however, Congress stated that three-judge proceedings cannot be convened unless

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"'population controls will solve California's prison health care problems '" *Id* the defendant is afforded time to comply with all of "the previous court orders" directed at remedying the alleged violation. *Id.* § 3626(a)(3)(A)(ii). By referring to the court's "orders" (plural) and using the definite article ("the"), Congress made clear its intent that a prisoner release order must be the final option, not one among many that might implement any previous order. *Id.*, see also *Kaufman* v *Allstate N.J. Ins. Co.*, 561 F.3d 144, 155 (3d Cir. 2009) ("the definite article preceding the term 'claims' ... means *all* the claims").

The requirements of subparagraph (ii) are not satisfied where, as here, the defendant has been given a reasonable amount of time to comply with an order at some earlier stage in the litigation, but not with the most relevant, recent remedial orders. If a court concludes that a less intrusive remedy may cure a constitutional violation, the PLRA commands that the court must give that remedy time to work.

2 The *Plata* court also wrongly believed that the State's prior inability to cure the alleged Eighth Amendment violations vitiated its obligation to afford the State time to effectuate the Receivership. See JS1-App. 279a-284a. No matter how the phrase "reasonable amount of time" is defined, it is clear that convening proceedings to consider whether to release prisoners two months after the Receiver issued a tentative plan—and prior to his final plan—is not "reasonable."

Indeed, the "reasonable amount of time" requirement must be assessed in light of Congress's express intent to avoid prisoner release and thus must take into account the work necessary to remedy the complained-of federal violations. Here, Judge Henderson vested the first Receiver, Robert Sillen, with authority to control CDCR's health care system with the understanding that the Receiver's work to remedy the alleged Eighth Amendment violations could potentially take years to accomplish. *Supra* at 14-15 & n.3; see JS1-App. 24a-29a (discussing problems that precipitated Receivership).[4]

Had reasonable time been afforded, the State's substantial (and ongoing) progress toward remedying the alleged constitutional violations under the Receiver's plans would have shown that there was no basis for convening three-judge proceedings. The Receiver's task was daunting. See, *e.g*, JA 1133 ("it [wa]s a misnomer to call the existing chaos a 'medical delivery system'—it is more an act of desperation than a system"). Yet, since Mr. Kelso's appointment as Receiver, *supra* note 4, he has clearly stated that the alleged Eighth Amendment violations can be cured by effectuating his plans without population reduction: "we believe we can provide constitutional levels of care *no matter what the population is*." Statement of J. Clark Kelso (Aug 13, 2008), *quoted in* JA 1236 [*Plata* D.E 1656, Ex. D (DVD) at 31:20 minutes] (emphasis added).

By June 2008, Mr. Kelso reported that "[t]here has already been significant progress" and "[s]ubstantial work has been completed at several prisons to improve conditions." JA 1127; see *e.g.*, *id.* at 1123-24, 1134-35 (plans). This progress has continued, and the State remains on track to effectuate Mr Kelso's plans within the timeframe he originally proposed. See, *e.g.*, JA 1547 (announcing in January 2010 that "there is much that prison healthcare stakeholders and advocates can showcase as accomplishments"); *accord Lifeline Newsletter* May 25, 2010, at 1, *available at* http.//www.cphcs.ca.gov/ newsletter.aspx (Receiver. the State recently has "move[d] us closer to ... bringing this matter to a *final close*") (emphasis added). In implementing the Receivership, the State has greatly increased funding for and improved access to medical care, dramatically improved staffing, finalized construction plans for new healthcare facilities, and enhanced its infrastructure and ability to provide adequate care. See JA 1547-49.

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[4] In June 2008, shortly after it replaced Mr Sillen with J Clark Kelso, the current Receiver, the court approved a revised Turnaround Plan of Action "establish[ing] a three- to- five-year framework for addressing all of the[] problems" affecting the provision of constitutional care JA 1125, *see* JA 2080 [Sept 4, 2008] (plan would be accomplished in "about four years") Mr Kelso contrasted his "fairly aggressive time frame" for action—a time frame that is plainly "reasonable"—with one lasting "10, 15 years before [a receivership] would finish its work, [which] simply is too long a time frame" *Id*

Healthcare funding per inmate has nearly doubled under the Receivership. JA 1219-20 ¶¶ 7-9; JA 2293-95. The Receiver spent $1.8 billion in fiscal year 2008-09 to provide medical care to the inmate population. Office of the Inspector General, *California Prison Health Care Receivership Corporation Use of State Funds for Fiscal Year 2008-09*, at 1 (June 2010), *available at* http.//documents reportingtransparency ca gov/Common/Document.ashx?ID=6384&TB_iframe=true

Moreover, although the court criticized the State's efforts prior to the Receivership, JS1-App. 280a, initiatives to improve access to care at each institution have been "ahead of schedule" since September 2008, JA 1202. The State showed "marked[] improve[ment]" throughout 2009, JA 1547; *id* at 1553-56 ("[a]ll institutions" improved access to care). Indeed, contemporaneous with the judgment, the Receiver announced that because "[p]atient-inmate access to health care has markedly improved," "we are projecting that control of the Health Care

Access Units *can be transferred back to CDCR* as early as next fiscal year, with a target for July 2011." *Id.* at 1547 (emphasis added); see *id.* at 1553-63 (completed actions and upcoming tasks).

Similarly, although the order convening three-judge proceedings suggested that the State's medical staffing shortages were intractable, JS1-App 284a, under the Receivership, the number of healthcare staff had increased significantly by the trial date. JA 1205-06. When trial began, the State was within five and two percent of the Receiver's goals for filling physician and registered nurse positions, respectively. JA 2249-50, 2250-51, see also JA 2066-69, 2071 (detailing exponential increases in staff) "Significant gains" have continued since trial. JA 1547-49, 1575-78. By February 2010, the Receiver had met his goal of filling over 90% of nursing positions and had filled 88% of physician positions JA 1643-49; see also Cal Prison Receivership, *Analysis of Year 2008 Death Reviews* 1, 23 (Dec. 14, 2009) ("*2008 Death Reviews*"), *available at* http://www.cprinc.org/docs/resources/OTRES_DeathReviewAnalysisYear2008_20091214.pdf ("significant systemic improvement[s]" in staff quality due to "wholesale transformation [of physician and nurse staff], especially between July of 2007 and August of 2008").

In effectuating the Receiver's plans, the State has improved the healthcare to the *Plata* class and will continue to do so. See, *e.g.*, JA 2249-50, 2250-52 (plaintiffs' expert Dr. Ronald Shansky testified that increased staffing has improved the quality of care); JA 2159, 2161 (plaintiffs' expert Dr. Jeffrey Beard acknowledged improvements in care). By trial, the number of deaths had been trending downward for 10 quarters, JA 2256-57, and the number of likely preventable deaths fell from 18 in 2006 to 3 in 2007, JA 2253, 2276-77 Additionally, the Receiver reported in December 2009 that the mortality rate has decreased 13.3% over the last three years, *2008 Death Reviews* 1, and the decreases are an even "more impressive" 24.3% when normal seasonal variations are taken into account. *Id.*, see also *id.* at 19 tbl.8 (five likely preventable deaths in 2008) These rapid successes demonstrate that had the *Plata* court applied the correct standard, it could not have convened three-judge proceedings

If this Court holds that the three-judge court should not have been convened in the *Plata* case, then the proper course is to reverse in both cases because the three-judge court's analysis depends inextricably on *Plata* to justify the prisoner release order. If Judge Karlton in *Coleman* believes that a three-judge court is still appropriate solely for that class-action, then the court can proceed accordingly after this Court reverses

B. The *Coleman* Court, Too, Erred When It Convened Three-Judge Proceedings.

On the same day that the *Plata* court convened three-judge proceedings, the *Coleman* court did too. JS1-App. 288a. It also erroneously held that the "reasonable amount of time" requirement was satisfied by non-compliance with some earlier orders that left unremedied the federal violations. *Id.* at 292a-297a.

The *Coleman* case has been in a remedial phase overseen by a court-appointed Special Master since before *Plata* was filed See JS1-App. 288a; see *id.* at 36a-37a (Special Master's supervision of Program Guide). The State has made "commendable progress" under the Special Master's direction over the years. *Id.* at 294a; see *id.* at 37a.

In January 2006, after negotiations, the Special Master recommended that the State's Revised Program Guide be approved. JS1 App. 37a, 294a. The *Coleman* court did so in March 2006. *Id.* at 38a; see *Coleman* D.E. 1772, 1773 (requiring, *inter alia*, that the State increase mental-health staffing and submit plans for reducing vacancies among psychiatrists and providing for sufficient mental-health inpatient beds). In June 2006, the remedial program changed again as Judge Karlton ordered the State to coordinate compliance efforts with the newly-appointed *Plata* Receiver. *Coleman* D.E. 2063, at 4:8-11; see also, *e.g.*, JA 1058 (agreements between Receiver and Special Master); *id.* at 1061-64 (Receiver's oversight of mental-health provider contracting and credentialing); *id.* at 1065-70 (Receiver's responsibility for mental-health records and pharmacy services); *Coleman* D.E. 1998, at 3 (requiring coordinated construction with efforts in *Plata*); cf. JA 1107-08 (coordination on construction).

Rather than allowing the State a reasonable amount of time to comply with this new remedial program, in November 2006, the *Coleman* plaintiffs moved to convene three-judge proceedings. At the time, the State was actively implementing the Revised Program Guide and plans regarding mental-health staff, beds, and suicides. See, *e.g.*, *Coleman* D.E. 1950, 1951, 1990, 1990-1.[5] The *Coleman* court nonetheless granted plaintiffs' motion.

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[5] *See also Coleman* D.E. 2061 & Attachs. 1-4 (suicide plan filed shortly after motion to convene), *Coleman* D.E. 2091 (long-range bed plan submitted in December 2006, and approved in

In finding § 3626(a)(3)(A)(ii) satisfied, the court did not examine whether the State had been given a reasonable amount of time to effectuate the Special Master and Receiver's most recent plans. JS1-App. 296a. Instead, Judge Karlton stated: "The orders of this court issued from 1995 through the present have failed to remedy the constitutionally inadequate delivery of mental health care," and "Defendants have had more than sufficient time to comply with the mandate required by the court's 1995 order and the numerous orders issued since then." *Id.* at 296a-297a As in *Plata*, the court improperly substituted previously unsuccessful remedial efforts for the requirement that the State be afforded a reasonable amount of time to comply with the court's orders.

Additionally, as in *Plata*, the State's progress in *Coleman* suggests that the time allotted to implement the Revised Program Guide and its plans regarding mental-health staff, beds, and suicides was not reasonable For instance, the *Coleman* court's decision to convene three-judge proceedings was driven by its view that the State's failures to provide sufficient mental-health staffing and to allocate other resources to the classmembers would be irremediable without population reduction. See JS1-App. 295a-296a & n.5; *id.* at 301a [6] Indeed, because of these

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April 2007, *see Coleman* D E 2200, subject to submission of supplemental plans to address two issues)

[6] During the hearing on the motion to convene, plaintiffs argued that the State's failure to devote sufficient resources, not crowding, was the root cause of the problem *See* JA 1659 [June 27, 2007] ("these cases, which are about—we're using the word 'overcrowding,' but it is not exactly—it doesn't exactly fit the cases that you're presiding over"), *id* at 1665 ("[T]his is *not* a case about where prisoners sleep It's a case about the demand and supply for services So they're increasing the demand for

purported resource allocation problems, the *Coleman* court rejected the State's plans to construct more space for housing and treating the classmembers, finding that the alleged Eighth Amendment violations would be "aggravate[d]" by such measures. *Id.* at 301a ("[T]his utterly fails to address the critical question of staffing.") Yet, the view that the State could not provide the necessary staffing and resources absent release proved erroneous once the plans of the Special Master and Receiver were given a reasonable amount of time to take effect.

Although mental-health care staff vacancies were high when the three-judge court was convened, JA 482-83; *Coleman* D.E. 2895, at 114-16 (reporting, *inter alia*, vacancy rates of higher than 40% and functional rates as high as 43% in May 2007), a recruiting and hiring program launched in November 2007 has been extraordinarily successful JA 1473, ¶ 48; *id.* at 1476-77, ¶¶ 57-60 (discussing, *inter alia*, 18% decrease in vacancy rate for psychologists over a six-month period). By trial, the Special Master recognized that certain facilities were fully staffed. See JA 2371, 2372. More recently, the Special Master reported that "the vacancy rate in mental health staffing at CDCR institutions continued the decline that had been found during the preceding monitoring period." JA 769 (footnote omitted). The overall vacancy rates for multiple staff categories fell to between 11% and 19% for the most recent reporting cycle. *Id* at 769-73; see *id.* (use of contractors reduced the functional vacancy rates to as low as 6%).

Furthermore, under the Special Master's recent oversight, the State added dedicated mental-health

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services, but where's the action on the supply side?") (emphasis added) beds at various institutions, which diminished waiting lists. JA 1483-84, ¶ 74; Defs.' Trial Ex. 1186 CDCR's institutions implemented functional and effective quality management programs. JA 773-74, 775-76; see also *id.* at 786-87 (noting "significant improvement" in providing medication). Numerous institutions have satisfied the Special Master's requirements for suicide prevention *Id* at 780. Additionally, the number of suicides has experienced declines, which the Receiver recently suggested may be directly attributable to "improved mental health care and improved security." *2008 Death Reviews* 23.

These improvements—*i.e.*, the State's dedication to supplying the services demanded—during the new phase of the remedial program demonstrate that the *Coleman* court's misinterpretation of § 3626(a)(3)(A)(ii) was material.

C. The Release Order Should Be Reversed For Lack Of Jurisdiction, And The Cases Should Be Remanded To Their Respective District Courts.

Because the three-judge court was not properly convened to consider prisoner release, this Court should reverse the judgment for lack of jurisdiction and dissolve the order creating the three-judge court. See *Gully* v. *Interstate Natural Gas Co.*, 292 U.S. 16, 18-19 (1934) (per curiam) (reversing judgment entered by improperly convened three-judge court and remanding to the single-judge district court); *accord Gonzalez* v. *Automatic Employees Credit Union*, 419 U.S. 90, 95 n.12 (1974); see also *Gully*, 292 U.S at 18 (where "there was no occasion for constituting a court of three judges," "the merits [of its decision] cannot be reviewed").

Finally, if the Court concludes that a three-judge court was inappropriate in either proceeding, then it still must reverse (see *supra* at 20). This Court cannot meaningfully review the merits of the three-judge court's order arising out of the combined cases and attempt to apply it only to one of the proceedings. At plaintiffs' urging, the three-judge court did not differentiate between the two cases in determining that a "prisoner release order" satisfied § 3626(a)(3)(E), or in shaping the remedy See, *e.g.*, JS2-App 2a-6a, JS1-App. 171a-172a[7] The three-judge court imposed the 137.5% cap to remedy alleged violations of *two* plaintiff-classes' Eighth Amendment rights without differentiating between them Determining the necessary remedy for just one class would require additional fact-finding. Therefore, if this Court concludes that three-judge proceedings were improper in either case, it should reverse the judgment in both cases and require the plaintiffs or the single judge in the other case to renew the request to seat a three-judge panel See 28 U.S.C. § 2284.[8]

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[7] Plaintiffs requested a release order that did not distinguish between the classes *See Plata* D E 1766, at 3, *see also Plata* D E 695, at 1-2 (arguing that the two cases should be heard by the same three-judge court), *Coleman* D E 2254 (same), *but see Plata* D E 701, at 2 (opposing consolidation)

[8] In ruling that *Plata* and *Coleman* should be consolidated for three-judge proceedings, then-Chief Judge Schroeder believed that the statutory requirement that she "shall designate two other judges," 28 U S C § 2284(b)(1), did not apply *See also id* (requiring that "the judge to whom the request [to convene] was presented" also be seated) Chief Judge Schroeder thus appointed only *one* judge, seating both Judges Henderson and Karlton JA 490-91 But if a three-judge court is proper in just one case, § 2284 would require the appointment of *only* the

II. REVERSAL IS WARRANTED BECAUSE THE COURT'S INTERPRETATION AND APPLICATION OF § 3626(a)(3)(E) IS CONTRARY TO THE PLRA.

If three-judge proceedings were proper in both cases, the judgment nevertheless should be reversed because the three-judge court erroneously interpreted § 3626(a)(3)(E). That provision requires a court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right, and ... no other relief will remedy the violation" before issuing a "prisoner release order."

A. The Court's § 3626(a)(3)(E) Holding Should Be Reversed Because It Has No Relation To, And The Court Expressly Refused To Consider, Current Conditions.

The Order to Reduce Prison Population should be reversed first because the district court failed to assess whether crowding *currently* "*is* the primary cause" of whatever Eighth Amendment violation remains and that no other relief "*will remedy*" such violations, both prerequisites to obtaining a prisoner release order. 18 U.S.C. § 3626(a)(3)(E) (emphases added). "Congress' use of a verb tense is significant ...." *United States* v *Wilson*, 503 U.S. 329, 333 (1992); *accord Carr* v. *United States*, 130 S. Ct. 2229, 2237 (2010) Congress's intentional use of the present and future tenses in § 3626(a)(3)(E) must be given meaning. Compare 18 U S C. § 3626(a)(3)(E), (1)(A), with *id.* § 3626(a)(3)(A) (present perfect and past tenses). The court below failed to do so.

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district judge who presided over that case, and the Chief Judge would "designate two other judges" as § 2284 commands

The three-judge court refused to hear evidence concerning the current status of alleged Eighth Amendment violations or whether the requirements of § 3626(a)(3)(E) presently are satisfied with respect to the current violations. See JS1-App. 78a n.42, JA 1691 [Nov. 10, 2008]. It mistakenly believed that such an inquiry was irrelevant because "defendants ha[d] never filed a motion to terminate under § 3626(b), the proper means for any challenge to the existence of 'current and ongoing' constitutional violations." JS1-App. 77a. But, the State's failure to move to terminate proceedings—which would have required a showing that *all* constitutional violations had been remedied—does not indicate either which Eighth Amendment violations had been cured or what measures are necessary to address any remaining violations

More significantly, crowding cannot be deemed the current "primary cause" of alleged violations to plaintiffs' federal rights without considering the specific effects that crowding allegedly *is causing* Likewise, it is not possible to determine what remedy is "necessary" without analyzing what violations currently *are in need of correction*. See, *e.g* , JA 2258 (plaintiffs' expert's admission that care at certain facilities may have satisfied the Eighth Amendment by the time of trial). The excluded evidence was crucial to the § 3626(a)(3)(E) determinations. Instead of conducting the required inquiry, the court below allowed plaintiffs selectively to employ any evidence of constitutional violations over a time period spanning years in *Plata* and *Coleman*. The court made the situation worse by refusing to consider evidence of prison conditions after August 30, 2008—even though the trial extended into February 2009 and the judgment did not issue until January 2010—

and by prohibiting testimony or discovery from the Receiver and the Special Master. See *supra* at 7.[9]

The limited inquiry allowed by the court was insufficient to determine whether crowding is the primary cause of "a substantial risk of serious harm" to the plaintiff-classes, *Farmer* v *Brennan*, 511 U.S 825, 834 (1994), and whether it is the primary cause of present "deliberate indifference" by State officials, *i e.*, "reckless disregard," *id.* at 838, of conditions "sure or very likely to cause serious illness and needless suffering," *Helling* v. *McKinney*, 509 U.S. 25, 33 (1993); see *Wilson* v. *Seiter*, 501 U.S. 294, 302 (1991). Likewise, it was inadequate to allow the court to determine whether any other relief "will remedy" any such substantial risk or end the State's purported deliberate indifference 18 U.S.C. § 3626(a)(3)(E).

Instead, the three-judge court's § 3626(a)(3)(E) analysis was a selective examination of what the alleged Eighth Amendment violations once were and a *post hoc* application of causation to those conditions See, *e.g.*, *infra* § II.B.2; JS1-App. 9a (relying on death statistics from mid-2005, while ignoring "significant and continuous decline since 2006," *2008 Death Reviews* 31), JS1-App. 19a-20a, 24a, 90a, 94a, 107a, 111a (fixating on conditions at the former San Quentin facility, but ignoring that it has been replaced by a state-of-the-art facility, see *id.* at 333a; *Plata* D.E 1652, at 6 ¶ 14; JS2-App. 52a; JA 1550). This violates the statute.

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[9] Although neither the Receiver nor plaintiffs objected to a noticed deposition, see *Coleman*, 2007 WL 4276554, at *1, acting *sua sponte*, the three-judge court assumed (wrongly) that the Receiver and the Special Master were protected by categorical quasi-judicial immunity *Id* at *1-2 The court failed to conduct the requisite functional analysis about whether all of the information sought involved mental processes within the Receiver's judicial capacity *See Antoine* v *Byers & Anderson, Inc*, 508 U S 429, 435-36 (1993), *United States* v *Morgan*, 313 U S 409, 422 (1941) This failure was significant because much of the information at issue pertained to administrative not judicial matters, and plaintiffs' expert admitted that the Receiver had "data" that was necessary to determine what would "achieve constitutional levels of care" JA 2273 It therefore was unreasonable for the court to conclude that categorical immunity applied *Cf Med Dev Int'l* v *CDCR*, 585 F 3d 1211, 1221 (9th Cir 2009) (reversing decision that the *Plata* Receiver was immune from suit)

The error is significant because of the disparity between the findings of Eighth Amendment violations upon which the court relied, and the current conditions on which a finding of necessity must be based. This point is further illustrated by assessing whether the State is acting with deliberate indifference. The three-judge court mentioned "deliberate indifferen[ce]" just once, and that was in the context of findings from *1995*. See JS1-App. 170a (discussing *Coleman* v. *Wilson*, 912 F. Supp. 1291, 1316, 1319 (E.D Cal. 1995)). The then-existing care and the *mens rea* of the former defendants are not comparable to those existing today Compare, *e g.*, JA 1133 (the State lacked a "medical delivery system" and was in "chaos" when the Receiver was appointed), and *Coleman*, 912 F. Supp. at 1322-23 (discussing weapons used against classmembers without penological justification), with, *e.g.*, *supra* at 18-19 (noting, *inter alia*, that the State now spends more than $1 8 billion per year on inmate health care), and JA 1635 (noting the "collaborative trust" forged among the Receiver, CDCR and the Governor's Office in remedying violations). The court should not have determined whether an injunction should issue today based solely on proof of violations in the past

See *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 59 (1987) (the "harm [the district court] sought to ... address[] ... [does not] lie[] in the present or the future, [but] in the past").

B. The Court Erred In Interpreting The PLRA's "Primary Cause" And "No Other Relief Will Remedy" Requirements.

The three-judge court misinterpreted § 3626(a)(3)(E)'s requirements that plaintiffs must present "clear and convincing evidence" that "crowding is the primary cause of the violation of a Federal right; and ... no other relief will remedy the violation." The best reading of § 3626(a)(3)(E) is that as the "primary cause" crowding must be at least the "but for" cause of the federal violation, and therefore that eliminating crowding alone should "remedy the violation of the federal right." This standard was not applied and could not be satisfied here.

1. In enacting the PLRA, Congress did not define "primary cause," and the legislative history is silent See JS1-App. 78a-79a & n.43. Congress has rarely used the phrase "primary cause" in other contexts, and those are not helpful here [10]

Nonetheless, it is clear that "primary cause" is distinct from and more substantial than a "contributing cause." See *Black's Law Dictionary* 250 (9th ed. 2009) ("contributing cause" is "[a] factor that—though not the primary cause—plays a part in producing a result"). To give meaning to the PLRA's intent to make prisoner release the remedy of last resort, JS1-App. 73a, "primary cause" should be read to require an elevated level of "but for" causation.

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[10] *See* 42 U S C § 9607(c)(2) (liability for costs of CERCLA response), Pub L No 111-22, § 1002(a)(1), 123 Stat 1663, 1664 (2009) (findings on "primary causes of homelessness"), Pub L No 110-180, § 2(B), 121 Stat 2559, 2560 (2008) (findings regarding "[t]he primary cause of delay in NCIS background checks")

This Court and other courts consistently have distinguished between "primary causes" and "contributing factors," which do not require "but for" causation This Court has explained that "concurrent" causes are distinct from the "primary" or "proximate efficient" cause of a particular result. *Rocco* v. *Lehigh Valley R.R.*, 288 U.S. 275, 278-80 (1933). It has held that an employee's failures could not be considered the "primary cause" of a resulting death because the acts of another could have been a cause "in whole or in part." *Id* In *The G.R. Booth*, 171 U S. 450 (1898), the Court concluded that the "primary and efficient cause" is that which is the "superior or controlling agency." *Id* at 460-61. The "primary cause" is the one from which damages "proceed[] inevitably, and of absolute necessity." *Id.*

Similarly, the Third Circuit has recognized that a "primary cause" must encompass "but for" and "proximate" causation, explaining that such standards are "significantly more stringent than [a] 'material contributing factor' test " ***Metro. Pittsburgh Crusade for Voters*** v. ***City of Pittsburgh***, 964 F 2d 244, 251 (3d Cir. 1992) (citations omitted); see also, *e.g* , *Hawkins* v. *Dir., Office of Workers Comp Programs*, 907 F.2d 697, 705 n 12 (7th Cir. 1990) (distinguishing contributing cause from "'principal, sole, primary, or proximate cause'" under the Black Lung Benefits Act); *Borras* v. *Sea-Land Serv., Inc* , 586 F.2d 881, 885-86 (1st Cir. 1978) (distinguishing contributing factor from "primary cause" under the Jones Act).

Moreover, prior to the PLRA, plaintiffs already were required to show that crowding was the proximate cause of the violation of their rights to obtain a remedy. See, *e.g.*, *Carver* v. *Knox County*, 887 F.2d 1287, 1294 (6th Cir. 1989); *Marsh* v. *Barry*, 824 F.2d 1139, 1143 (D.C. Cir. 1987) (per curiam); *Abrams* v. *Hunter*, 910 F. Supp. 620, 627 (M.D. Fla. 1995), *aff'd*, 100 F.3d 971 (11th Cir. 1996). Congress is presumed to have knowledge of existing law when it enacted the PLRA. *Goodyear Atomic Corp.* v. *Miller*, 486 U.S. 174, 185 (1988). In enacting the PLRA, Congress's clear purpose was to limit the remedies available in prison overcrowding cases, not to make the remedy more readily available. 18 U.S.C. § 3626(a)(1), (3)(E); H.R. Rep. 104-21, at 11, 25 (1995), JS1-App. 248a. Thus, by adding "primary" to the pre-existing causation requirement, the PLRA's causation standard is best understood to require special and heightened judicial scrutiny.

The three-judge court violated these rules. Although it purported to accept the State's argument that primary cause is that which is "'first or highest in rank or importance; chief; principal,'" JS1-App. 78a, the court did not actually apply such a standard. Rather, it treated "primary cause" as if it were synonymous with a "contributory cause."

The district court acknowledged that the alleged Eighth Amendment violations resulted from numerous causes, many of which pre-dated the crowding at issue. See, *e.g.*, JS1-App. 16a-17a, 31a-52a, 85a-95a, 104a-126a. The complete lack of a *system* for providing care and a troubled institutional culture at the outset of these litigations were the driving forces resulting in constitutional violations. See, *e.g.*, JA 1124 ("pervasive, fundamental organizational weaknesses and failures"); *id.* at 1133 ("it is a misnomer to call the existing chaos a 'medical delivery system'"); *Coleman*, 912 F. Supp. at 1298-99; *Plata* v. *Schwarzenegger*, No. C01-1351-TEH, 2005

WL 2932253, at *29 (N.D. Cal. Oct. 3, 2005) (identifying the "historical lack of leadership, planning, and vision by the State's highest officials") [*reproduced at* JA 974].

Addressing these systemic issues has been a substantial task, see *supra* at 17, and crowding can strain reform efforts. See, *e g* , *Plata* D.E 2031, at 2:13-16. The fact that crowding may slow the progress of other remedies does not make it the "primary cause," or indicate that prisoner release is "necessary." On the contrary, the existence of multiple and interrelated conditions necessary to remedy the alleged constitutional violations should have foreclosed prisoner release. The district court acknowledged that curing the crowding would not remedy the alleged violations because independent (*i e* , primary) causes would continue to produce constitutional injury. JS1-App. 134a, 143a. Yet, by treating crowding's contribution to other causes as sufficient to make it the "primary cause," the district court eviscerated § 3626(a)(3)(E)(ii)'s requirement that "*no other relief* will remedy the Federal right." (emphasis added) If overcrowding is the primary cause, then eliminating overcrowding should undo all or virtually all of the constitutional harm.[11]

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[11] Plaintiffs claimed that because crowding slows multiple remedial efforts, it must be the primary cause of the Eighth Amendment violations "[A]ll of the evidence shows that overcrowding is inhibiting the remedial efforts of both the courts and the Special Master and the Receiver in this case And therefore, it is delaying the constitutional remedy" JA 1659 [June 27, 2007], JA 1377, ¶ 4 (Shansky "[T]he inadequate system will continue to exist for longer than it would otherwise unless there is a significant reduction in the population") In virtually any systemic prison conditions case, crowding would make remedying existing violations more difficult But under the three-judge court's reading, crowding automatically would

The record makes clear that this would not happen here. The Special Master, for instance, explained that "'even the release of 100,000 inmates would likely leave the defendants with a largely unmitigated need to provide intensive mental health services to program populations.'" JS1-App. 157a (alteration omitted); see *Plata* D.E. 2031, at 23-26 (most *Coleman* classmembers are housed in crowded conditions, and suicides are most prevalent in single-cell conditions). Plaintiffs' expert Dr. Shansky agreed that CDCR will not have constitutionally adequate medical care "[i]f the only improvement that was made ... is ... there are 40,000 less inmates." *Plata* D.E. 1481-3, at 61:14-24; see also JS1-App. 282a (Receiver explained that it was "'simply wrong'" to believe "'that population controls will solve California's prison health care problems'").

In contrast, the Receiver concluded that the State could "provide constitutional levels of care *no matter what the population is*" once his plan was fully implemented. *Supra* at 17. Likewise, Dr. Shansky repeatedly has conceded that "the full implementation of the [T]urnaround [P]lan will ensure a constitutional level of healthcare and mental health care in California." JA 2280-81; JA 1376-77, ¶ 4.[12]

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be the "primary cause" in these circumstances and, contrary to the PLRA, a prisoner release order could issue whenever a three-judge court is frustrated by the speed of less intrusive relief.

[12] Dr. Shansky stated that the Receiver's plan alone would be sufficient unless the prison population "wildly increases again." JA 2280-81. Irrespective of the relief ordered here, California is committed to reducing crowding and recently has been the most successful jurisdiction in the country in doing so. *See* U.S. Dep't of Justice, *Prison Inmates at Midyear 2009—Statistical Tables* 1-2 & fig. 2 (June 2010); Pew Ctr. on the States, *Prison Count 2010*, at 5 (Apr. 2010).

Indeed, Judge Henderson's comments show that the three-judge court's determinations did not satisfy § 3626(a)(3)(E)'s requirements.

> [R]educ[ing] the prison population will not address the *core issue* in *Plata*, nor will it alleviate the reasons for the Receivership and my oversight over the prison's medical health care delivery system. Instead, a reduction in the prison population would simply resolve the plaintiffs' argument that overcrowding is the primary cause of the constitutional violations.

JA 1861 (emphasis added). This use of "primary cause" illustrates that the court below treated the phrase as if the PLRA merely required a "contributing-cause" showing.

In sum, plaintiffs' experts, the district court, the Receiver, and the Special Master agree that the Eighth Amendment violations will *not* be cured by relief directed at crowding alone. They recognize that the other remedies are *necessary* and, indeed, may be sufficient to bring about constitutional care, while relief directed at crowding, at most, may expedite those other remedies. In these circumstances, a prisoner release order may not issue. Instead, the trial court must focus on the other remedies that will remedy Eighth Amendment violations, if any remain, in due course, and it is the problems to which those remedies are directed that are the primary cause of the alleged Eighth Amendment violations.

2. Finally, the court's conclusion that "all other potential remedies will be futile in the absence of a prisoner release order" is not supported by clear and convincing evidence. JS1-App 144a-145a. The three-judge court considered and rejected four potential types of remedies as inadequate.

(1) construction, *id.* at 145a-154a; (2) additional hiring, *id.* at 154a-155a, (3) ongoing efforts of the Receiver and Special Master, *id.* at 155a-159a, and (4) transferring inmates, *id.* at 159a-162a. The court erred by analyzing and rejecting the potential measures in isolation rather than examining their cumulative effect and by unreasonably dismissing their individual effectiveness. See *id.* at 144a-162a.

Construction. The court rejected the State's argument that its implementation of legislation enacted shortly before trial (AB 900) and willingness to construct facilities would constitute less intrusive remedies than prisoner release See JS2-App. 2a; JS1-App. 145a-154a.

The court first erred by declining to credit plaintiffs' experts' testimony that prison construction helped remedy federal law violations in systems they administered, JA 2182-83, 2185, and that the construction of additional treatment facilities in California could remedy the alleged violations, *id* at 2165-66, 2259-60; see also Fed. Bureau of Prisons ("BOP"), *State of the Bureau 2008*, at 6 (2008) (agency "reduc[es] crowding by adding additional bed space"). It compounded that error by reasoning that the State's construction proposals were infeasible because "it will be years before any re-entry facility construction ... will be completed" JS1-App. 147a-148a. The court's reasoning is internally inconsistent. The court *sua sponte* stayed its prisoner release order pending appeal, once effective, that order will take *two years* to implement. JS2-App. 8a-9a.

During that time, construction that could be a partial remedy will occur. Prior to judgment, the State filed construction plans to satisfy the Receiver's proposals and the *Coleman* court's orders requiring that the State implement a long-range bed plan to provide sufficient housing and treatment facilities for the classes, including waiting lists affecting portions of the *Coleman* class. *Coleman* D.E. 3724 & Attach. A. The Receiver called those construction plans "'an extraordinary milestone.'" *Lifeline Newsletter* Nov. 24, 2009, at 1, *available at* http://www.cphcs.ca.gov/newsletter.aspx; *Plata* D.E. 2325, at 1 (noting legislature's approval of construction), JS2-App. 11a-16a (approving plans, but ordering changes to the activation schedules for several facilities). Under these plans, thousands of new beds are to be added to the CDCR system. See *Coleman* D.E. 3724, Attach. A, at 10-11. The facilities will begin accommodating inmates this year, see, *e.g.*, *id.* Ex. 16; *Coleman* D.E. 3866, and all facilities are to be completed by 2014.[13]

Additional Hiring. The court rejected additional hiring as a less intrusive form of relief. See JS1-App. 154a-155a; JS2-App. 2a. As shown *supra* § I, the relevant hiring trends were extremely positive between 2007 and 2008. The court declined to recognize these improvements despite the evidence of such progress at trial. See, *e.g.*, *supra* at 19, 23. Moreover, by the time of the Order to Reduce Prison Population, the Receiver had met his goals for staffing the health care system. *Id.* at 19. Nonetheless, the three-judge court relied on the staffing levels in 2007 and before to dismiss this potential remedy. JS1-App. 154a; see, *e.g.*, *id.* at 28a, 47a-48a & nn.31-34.

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[13] *Coleman* D.E. 3724, Attach. A, *Coleman* D.E. 3830 (revising activation schedule for one facility as ordered), *Coleman* D.E. 3794 & Ex. A (expediting activation schedule for another facility), JA 835-36, 848-51 (revising activation schedules), *Coleman* D.E. 3866 (approving revised activation schedules and waiving state regulations to expedite activation).

Emblematic is the court's crediting of outdated evidence that: "[CDCR] lacks sufficient custodial staff 'to keep prisoners safe from harm' or 'to provide ... timely access to care.'" JS1-App. 110a; see *id.* at 101a. This ignores that CDCR hired 600 and 1800 custodial staffers in 2007 and 2008, respectively, and that officers serve in dedicated "access to care" units to escort inmates to medical and mental-health appointments. JA 2483-84. Indeed, by trial, CDCR "literally filled up all of [its] prisons with correctional staffing" and planned to cancel academies for additional staff because "we are actually overfilled." *Id.* at 2484.

Thus, by the time of trial and when the judgment issued, the court had no basis to conclude that continued staffing increases—whether alone or in concert with other measures—would not remedy the alleged violations.

The Receiver and the Special Master's Ability to Remedy Alleged Violations Absent Release. Clear and convincing evidence does not support the court's claim that the tools available to the Receiver and the Special Master are insufficient to remedy the alleged violations absent a prisoner release order. See JS1-App 155a-159a; JS2-App. 2a.

As discussed, the Receiver and Dr. Shansky have acknowledged that full implementation of the Receiver's plans *alone* will be sufficient to ensure Eighth Amendment care *Supra* at 17, 34-35; see also JA 2434 (plaintiffs' expert Dr. Austin: "'[Q.] Is it your opinion that no matter what resources he has or what actions he takes, the Receiver cannot provide for constitutional levels of medical care at current population levels? [A.] No.'") The three-judge court's failure to give any weight to the positive developments under the Receivership and Special

Mastership that occurred between the August 2008 close of evidence and the judgment makes matters worse. See *supra* §§ I, II.A.

Out-of-State Transfers. Finally, the three-judge court erred in rejecting the possibility of transferring inmates to out-of-state facilities as part of a remedy. JS1-App 159a-162a; see JS2-App. 2a It asserted that the number of transfers to-date and proposed in the future were "too small to significantly affect the provision of medical and mental health care to California's inmates." JS1-App. 160a.

This overlooks that Judge Karlton erroneously blocked the State's efforts to transfer mental-health prisoners to out-of-state facilities to address crowding. See JA 435, , ¶¶ 1, 5 (allowing CDCR to transfer only 80 non-*Coleman* classmembers, and ordering that "[n]o other CDCR inmates are to be transferred" unless pre-transfer screening requirements proposed by the Special Master were satisfied) Judge Karlton prohibited transfers based on the Special Master's concern, *id* ¶ 3, that "the actual state of mental health services" at the *out-of-state transferee institutions* would not provide sufficiently high quality care, see JA 439-40. It was mistaken to *presume* that the mental-health care at out-of-state facilities does not satisfy the Eighth Amendment. In these circumstances, the three-judge court should have refused to order prisoner release unless the district courts allowed the State to exhaust its avenues for prisoner transfer

The three-judge court failed to account for these various remedial measures individually and cumulatively. Even if it were appropriate to discount the Receiver's belief that, as discussed above, the tools available to him alone would be sufficient to remedy any alleged Eighth Amendment violations, it certainly is the case that the combination of the remedial measures discussed here could be a sufficient remedy and the three-judge court was obliged to deal with their cumulative effect before ordering prisoners released from confinement.

III. THE RELEASE ORDER VIOLATES THE PLRA'S HEIGHTENED REQUIREMENTS OF NARROW TAILORING AND FAILS TO GIVE SUBSTANTIAL WEIGHT TO PUBLIC SAFETY.

Even if § 3626(a)(3)(E) were satisfied, the order capping the system-wide population of CDCR's facilities at 137.5% of their design capacity must be reversed. The remedy violates the PLRA's heightened requirement of narrow tailoring, *i.e.*, that injunctive relief shall be "narrowly drawn," extend "no further than necessary to correct the violation of the [Eighth Amendment] right[s] of ... plaintiffs," and be "the least intrusive means necessary to correct the violation." 18 U.S.C. § 3626(a)(1)(A), JS1-App. 75a (calling these requirements the "need-narrowness-intrusiveness" standard); see JS2-App. 2a; JS1-App. 168a-185a. The order also fails to give sufficient weight to adverse impacts on public safety and the State's operation of its criminal justice system. 18 U.S.C § 3626(a)(1)(A), see JS2-App 4a; JS1-App. 185a-254a.

A. The 137.5% Cap Lacks Any Nexus To The Alleged Violations Of Plaintiffs' Eighth Amendment Rights, Is Not Narrowly Drawn, And Is Highly Intrusive

The order requires that the population of California's prisons be capped at 137.5% of their combined design capacity within two years JS2-App. 5a-6a. The State must reduce its prison population by between 38,000 and 46,000 inmates, depending on CDCR's ordinary population fluctuations. JS1-App. 235a, *Plata* Appellees' Mot. Dismiss, No. 09-1233, at 3-4 n.1 (U.S. May 14, 2010). The court claimed that "California's prisoner population *must* be reduced to some level between 130% and 145% design capacity if the CDCR's medical and mental health services are ever to attain constitutional compliance." JS1-App. 183a. It selected a system-wide cap of 137.5% design capacity because it was "halfway between the cap requested by plaintiffs and [a group of] wardens' estimate of the California prison system's maximum operable capacity" *in 2004*. *Id.* at 184a.

None of these three figures has any nexus to the alleged Eighth Amendment violations in this case. Each of the reasons below is individually sufficient to require reversal. Collectively, they demonstrate that the three-judge court used its prisoner release order to effectuate broad policy goals that are incompatible with the PLRA and ignored federalism concerns and the necessary separation of powers in doing so.

1 The 137.5% cap should be reversed because it has no connection to current prison conditions, including any alleged Eighth Amendment violations that continue to exist. See *supra* § II.A; 18 U.S.C. § 3626(a)(1)(A) (present tense). Moreover, "'the nature and scope of [an injunctive] remedy are to be determined by the violation.'" *Missouri* v. *Jenkins*, 515 U.S 70, 88 (1995). Thus, any current violations should have provided the starting point for the nexus analysis. See *id.* They did not. As discussed above, the three-judge court refused to consider evidence of prison conditions subsequent to August 30, 2008. The court could not lawfully craft a prisoner release order that met the PLRA's heightened tailoring requirements without considering the conditions that

existed at the time it imposed that remedy. For example, whatever population reduction may have been necessary in light of evidence about conditions prior to August 2008, that number surely declined after the State's intensive remedial regime took effect. The 137.5% cap should be vacated on this basis alone.

2 In any event, plaintiffs failed to demonstrate the required connection between the 137.5% of design capacity population cap and any effort to remedy the State's alleged *Eighth Amendment* violations Plaintiffs were required to show that a 137.5% cap is necessary to prevent a "substantial risk of serious harm," *Farmer*, 511 U S. at 834, and to extinguish the State's purported "deliberate indifference," *id.* at 838. Plaintiffs did not carry their burden

To understand the error of the 137.5% of design capacity cap, it is first critical to comprehend what "design capacity" means in California's prisons "Design capacity" is a term of art that refers to the number of inmates CDCR's prisons may house based on one inmate per cell, single bunks in dormitories, and no beds in space not designed for housing. JS1-App. 57a. California, however, "has never limited its prison population to 100% design capacity," because, *inter alia*, its prisons frequently were planned and built to double-cell inmates. *Id.* A facility intended to house two inmates per cell that houses two inmates in each cell (and thus is not overcrowded) is nonetheless at 200% of "design capacity." Equally important, housing two inmates in a cell designed for one does not violate the Eighth Amendment. *Rhodes* v. *Chapman*, 452 U.S. 337, 348 (1981). Neither plaintiffs' proofs at trial, nor the court's findings, take these realities into account.

At trial, plaintiffs requested a system-wide cap of 130% of design capacity. They did so because 130% of design capacity purportedly is "the federal standard for prison overcrowding," JS1-App 180a—it is not Regardless, plaintiffs did not link that population level to the State's ability to satisfy its obligations under the Eighth Amendment. *Id.* at 183a. Nor is there any nexus between the Eighth Amendment and the 145% cap that the district court treated as the outer bounds for any population reduction. See *id.* at 143a, 184a.

First, the so-called "federal standard for prison overcrowding" is actually a goal that the BOP set shortly before this trial In 2005, BOP announced a "population management" goal, stating that it would "work toward *ultimately achieving* an overall crowding level in the range of 30 percent [*i.e.*, 130% overcrowding] " BOP, *State of the Bureau 2005*, at 7 (2005) (emphasis added); see also JS1-App 179a-180a (CDCR's "long-term" goal that population not exceed 130% design capacity).[14] There is no evidence that BOP's aspirations have any connection to Eighth Amendment *minima* for medical and mental-health care. On the contrary, BOP clearly aims to exceed the Eighth Amendment: "The BOP delivers mental health services comparable to mental health care in the community." *State of the Bureau 2008*, at 32; see *id.* at 7-8 (quality of health care).

BOP's population levels, however, routinely exceed its goals. For instance, in 2003, the crowding rate for

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[14] BOP does not measure crowding using "design capacity " It uses a different term of art, "rated capacity," as "the baseline for the statistical measurement of prison crowding " BOP, *Program Statement Rated Capacities for Bureau Facilities* 1, No 1060 11 (June 30, 1997) Critically, "[r]ated capacity is not necessarily the same as any institution's design .. capacity " *Id* at 2

BOP's prisons increased from 33 to 39 percent, and crowding at high and medium security prisons was "significantly higher at 59 percent apiece." BOP, *State of the Bureau 2003*, at 7 (2003); see also, *e.g.*, BOP, *State of the Bureau 2004*, at 7 (2004) (41% percent crowding). In 2008, three years after setting the "population management" goal, BOP still had a crowding rate of 36 percent, with high- and medium-security facilities at 50 and 44 percent, respectively. *State of the Bureau 2008*, at 2. None of these reports links BOP's conditions or goals to constitutional *minima*

Second, the 145% of design capacity cap that the district court considered likewise has no connection to the Eighth Amendment. See JS1-App. 59a, 181a. The 145% figure was drawn from a study conducted by California's Corrections Independent Review Panel, a group of wardens. See *id.* That Panel determined *in 2004*—before numerous subsequent improvements, *supra* §§ I, II—that CDCR's "operable capacity" was 145% of its design capacity. See JS1-App 59a. "'[O]perable capacity,' refers to 'the maximum capacity of the prisons to house inmates safely and securely while providing *effective education, training, and treatment*.'" *Id.* (emphasis added) (operable capacity "'takes into account space needed for effective programming'"). Therefore, "operable capacity" plainly is not aimed at any Eighth Amendment standard See, *e.g.*, *San Antonio Indep. Sch Dist.* v. *Rodriguez*, 411 U.S 1, 35 (1973) (public education is not a right guaranteed by the Constitution); *Hoptowit* v. *Way*, 682 F.2d 1237, 1255 (9th Cir. 1982) ("There is no constitutional right to rehabilitation."); cf. *Lewis* v *Casey*, 518 U S. 343, 350 (1996). See also JS1-App. 181a ("Operable capacity [as used in the study] d[id] not take into account the ability to provide [medical and mental-health] care [that would satisfy the Eighth Amendment].").

Accordingly, the three-judge court erred in treating the 130% and 145% figures as the poles for assessing constitutionality. Indeed, this Court has held that a lower court "err[s] in assuming that opinions of experts as to desirable prison conditions suffice to establish contemporary standards of decency . '*[T]hey simply do not establish the constitutional minima*; rather, they establish goals recommended by the organization in question.'" *Chapman*, 452 U S. at 348 n.14 (emphasis added) (quoting *Bell* v. *Wolfish*, 441 U.S. 520, 544 n.27 (1979)). Because the court treated these goals as Eighth Amendment *minima*, the judgment should be reversed.

Finally, plaintiffs' experts' testimony cannot support the judgment. They relied on the same professional goals noted by the court and uniformly denied that they could assess the population reduction required to provide care consistent with the Eighth Amendment.

For example, Dr. Ronald M Shansky, the former Medical Director of the Illinois State Prison System, testified·

> [Q] Isn't it true ... that you hesitate today to come up with a figure to which the prison population needs to be reduced to achieve constitutional levels of care, because .. that would require doing a study that requires data from the *Plata* Receiver?
>
> A. Yes, that's correct.

JA 2273 Dr. Shansky added that he had "no clue" what population reduction would be necessary to bring about care that satisfied the Eighth

Amendment *Id.* at 2279-80. Jeanne Woodford, a former CDCR warden, similarly testified that she was unaware of any study that determined what population reduction would be necessary "to provide constitutionally-adequate medical and mental healthcare in California's prisons." JA 2424-25 Additionally, Dr. Craig Haney, a professor who serves as an expert in prison conditions cases, admitted that he did not "'know how to calculate'" what CDCR would need to do to show compliance with the Eighth Amendment. Tr 342:15-23; see also JA 2393. Instead, like the court, he treated the wardens' estimate that operable capacity was 145% of design capacity as a constitutional benchmark, although he had no idea how the wardens calculated that number. JA 2388-89; compare JS1-App. 183a (nonetheless relying on Dr. Haney's report as evidence of what was necessary to eliminate Eighth Amendment violations).[15]

Indeed, plaintiffs effectively confessed that their remedies case was not linked to satisfying the Eighth Amendment. Their experts were unaware of the level of care provided to the class members, and had not evaluated CDCR's ability to provide constitutional care. See, *e g.*, JA 2179 (Lehman: "Q. In preparing your report, you did not know what the space needs were for medical or mental healthcare in California's prisons, did you? A Specifically, no."), *id.* at 2180 ("Q ... [Y]ou did not have knowledge of the status of medical health care delivery in California's prisons as of August 2008, did you? A. No ...."), JA 2122 (same from plaintiffs' expert Wayne Scott); JA 2218, 2219 (similar from Ms Woodford) Thus, their testimony was not relevant to the critical issue under the PLRA—the reduction *necessary* to provide care that complies with the Eighth Amendment floor See, *e.g.*, *Farmer*, 511 U.S. at 834; *Chapman*, 452 U.S. at 347.

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[15] Even if plaintiffs' experts had addressed the relevant nexus to the Eighth Amendment, their admissions that they were able to provide constitutional health care in more overcrowded prison systems would have undercut their testimony *See* JA 2138, 2141, 2142, 2163-65 (Dr Beard provided constitutional care when Pennsylvania's system was 150-160% of design capacity, including at a facility "over . two hundred percent of capacity"), JA 2177, 2181 (Lehman constitutional care in Washington and Pennsylvania at 150% crowding and above), JA 2271-72 (Shansky constitutional care in Illinois at 140% crowding)

Instead, the experts testified only that the requested reductions would prove beneficial to the wardens, their staff and the inmates As the three-judge court acknowledged, plaintiffs' request was based on testimony regarding the level required for a "prison system ... to function *properly*" or "'*appropriately*.'" JS1-App. 177a-178a (emphases added). Dr. Beard, for instance, testified that it "is impossible to really do a good job" as warden when prison population exceeds 150% of design capacity. JA 2142; see *id.* at 2141. When pressed by the court about what this meant, Dr. Beard did not point to any Eighth Amendment benchmark. *Id.* at 2143; see *id.* at 2137-38, 2157

Plaintiffs' closing argument at trial is telling·

> In terms of the 130 percent issue, we agree with your comments yesterday that it's not an exact science. But what it is, is a consensus among experts that we've used and, ... Jeanne Woodford, who ran the prison system and who worked there 28 years, thinks *it's a reasonable number and will get us to where we want to go. It seems to me that's a pretty reliable piece of evidence upon which to base a decision.*

JA 2563 (emphasis added). The PLRA does not allow a prisoner release order to issue based on what experts deem *reasonable*, it requires that release be the "least intrusive means *necessary*" to remedy alleged Eighth Amendment violations. The evidence here does not satisfy § 3626(a)(1)(A).

In sum, the three-judge court imposed the 137.5% of design capacity cap even though the record contains no evidence supporting a nexus between plaintiffs' request and the alleged Eighth Amendment violations Instead, the court usurped the role of the political branches, erroneously substituting its own policy preferences about prison conditions for what the PLRA and the Eighth Amendment require. See *Chapman*, 452 U.S. at 349 (professional standards may "reflect an aspiration toward an ideal environment for long-term confinement," but "properly are weighed by the legislature and prison administration rather than a court") Plaintiffs did not satisfy the PLRA, they sought systemic prison reform. *Accord Plata* D.E. 1766, at 1-7 (plaintiffs' trial brief) (failing to explain why reductions are *necessary* to remedy Eighth Amendment rights, but focusing on how a "population reduction order could *improve* public safety and the administration of criminal justice systems throughout the state"). The district court's order should be reversed on this basis alone.

3. The court below failed to limit the prisoner release order to what is necessary to remedy the violation of *plaintiffs'* rights, thereby violating not only the PLRA, but also the requisite constraints on injunctive relief and fundamental principles of federalism. In fact, the court acknowledged that the relief "extends further than the identified constitutional violations" insofar as it "is likely to

affect inmates without medical conditions or serious mental illnesses." JS1-App. 172a.

First, as a result, the injunction contravenes the PLRA which provides that injunctive relief shall "extend[] *no further* than necessary to correct the violation of the Federal right of ... particular ... plaintiffs," *i.e.*, the class members 18 U.S.C. § 3626(a)(1)(A) (emphasis added); see also H.R. Rep. No 104-21, at 24 n.2 ("[T]he provision stops judges from imposing remedies intended to ... provide an overall improvement in prison conditions."); cf *Casey*, 518 U.S. at 364 (Thomas, J., concurring).

Second, the relief violates the permissible scope of a federal decree. The order breaches the rule that "only if there has been a systemwide impact may there be a systemwide remedy." *Dayton Bd. of Educ.* v. *Brinkman*, 433 U.S. 406, 420 (1977) In *Jenkins*, this Court held that "'federal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate the Constitution or does not flow from such a violation.'" 515 U.S. at 98. There, the Court reversed an interdistrict desegregation remedy, explaining that "[t]he proper response to an intradistrict violation is an intradistrict remedy" *Id.* at 90; see *id.* at 90-92. Similarly, in *Casey*, the Court struck down a systemwide injunction that sought to remedy multiple inadequacies in prison administration, not merely those found to "have harmed ... plaintiff in th[e] lawsuit." 518 U.S. at 357-58 (rejecting argument that class action authorized broader relief); see also *id.* at 359.

These principles apply here. The alleged constitutional violations affect two discrete plaintiff-classes. Yet, rather than specifically addressing the alleged Eighth Amendment violations sustained by members of the two classes, the court ordered prison-wide relief There is no basis for a systemwide remedy for the alleged Eighth Amendment violations in this case because the quality of care varies by facility and plaintiffs conceded that the conditions in some facilities already may satisfy the Eighth Amendment despite their overcrowding. See, *e.g.*, JA 2258 (Dr. Shansky). Moreover, a remedy spanning both classes is not narrowly tailored because crowding does not affect individuals with severe medical problems and the mentally ill (let alone different types of mentally ill prisoners) in the same manner. Indeed, it is unclear whether a prisoner release order that does not differentiate between class members and the prison population as a whole can be deemed narrowly tailored in light of the violations at issue.

Third, the "Order to Reduce Prison Population" contravenes principles of federalism and the prerogatives of the political branches generally. See *Jenkins*, 515 U.S. at 98-99, *id.* at 114, 124-34 (Thomas, J , concurring); 18 U.S.C. § 3626(a)(1)(A). In *Jenkins*, the Court reaffirmed that courts must be especially cautious in imposing injunctive relief that threatens "'the interests of state and local authorities in managing their own affairs.'" 515 U.S at 98, see *id.* at 99, *Horne* v *Flores*, 129 S. Ct. 2579, 2593-94 (2009).

Here, the state and local interests are at their zenith: "It is difficult to imagine an activity in which the State has a stronger interest ... than the administration of its prisons." *Preiser* v *Rodriguez*, 411 U.S. 475, 491-92 (1973); see also, *e.g* , *Casey*, 518 U.S. at 362-63; *Chapman*, 452 U.S. at 352; *Turner* v *Safley*, 482 U.S. 78, 84 (1987), *Wolfish*, 441 U.S at 548. The PLRA further emphasizes those interests, requiring the court to "give substantial weight to any adverse impact on ... the operation of the criminal justice system" in considering injunctive relief. 18 U.S.C. § 3626(a)(1)(A). See 141 Cong. Rec. S2648, S2649 (daily ed. Feb. 14, 1995) (Sen. Hutchison) ("[t]his bill will curb the ability of Federal courts to take over the policy decisions of State prisons").

In ordering a systemwide remedy, the three-judge court did not consider the burden placed on the State as it simultaneously must comply with the court's order and the less intrusive, but nonetheless robust remedies previously imposed by the Receiver and Special Master—remedies which directly affect the classmembers. Additionally, because it is not feasible, as Judge Karlton recognized, to accomplish population reduction by releasing class members alone, see JA 2389-90, 2450-51, the court's order requires the State to reform how it incarcerates criminals outside the plaintiff-classes. See JS2-App. 39a-42a, 45a, 63a-64a (parole reforms and alternative custody).

Finally, the court attempted to justify the imposition of the prisoner release order on the basis that it was more protective of the State's interests. This assertion is misguided. The court claimed that "a systemwide population reduction ... is preferable to an order ... requiring particular methods of population reduction," as it purportedly exhibits "deference to state expertise." JS1-App. 174a-175a (internal quotation marks omitted), JS2-App. 3a. The court *rejected* institution-specific relief, claiming that the State "ha[d] never contended that the problems at issue in *Plata* and *Coleman* are institution-specific." JS1-App. 171a. The court was mistaken. In fact, the State elicited testimony from plaintiffs' experts that certain institutions may be in constitutional compliance notwithstanding their populations.

Supra at 50. The State also adduced evidence that the problems about which plaintiffs complained were unique to and variable among specific CDCR institutions. See, *e.g.*, JA 2104-05 (discussing Special Master's findings, *Coleman* D.E 3029-1, at 6, that several institutions were in substantial compliance with the court-approved policies and procedures for providing mental-health care); JA 2122-25, 2127 (plaintiffs' expert's testimony that he was unfamiliar with the staffing levels or quality of care provided at a number of specific institutions); Defs.' Trial Ex. 1074, at 1 (in-person monitoring of California Women's Facility was no longer necessary) The PLRA requires consideration of the fact that certain facilities were in compliance.

The claim that the order provides the State with flexibility is likewise misplaced. Although the court did not dictate specific measures for achieving population reduction, its order is not deferential. It compels the State to reform its correctional practices on the whole rather than targeting relief at *either* of the plaintiff classes. Moreover, in implementing the three-judge court's ruling prior to its *sua sponte* stay of relief, Judge Karlton held that he would not approve a housing plan in *Coleman* "as long as [it] calls for a projected population in excess of 137 5% of the facility's design capacity." JS2-App. 13a; see JA 860-61 (delaying imposition of the facility-specific mandate pending this appeal). Under Judge Karlton's understanding, the 137.5% cap does not give the State flexibility to implement the population reductions systemwide, but instead acts as a facility-by-facility ceiling that deprives the State of meaningful discretion to manage particular facilities. In sum, the operation of California's prisons is now under the clear control of a federal court and the court's purported "deference" to how the State does the federal court's bidding does not alter that fundamental fact.

B. The Court's Order Does Not Give "Substantial Weight" To The Adverse Impacts On Public Safety That The Prisoner Release Order Will Cause.

The court failed to "give substantial weight to any adverse impact on public safety" caused by the Order to Reduce Prison Population. 18 U.S.C. § 3626(a)(1)(A), see also H.R. Rep. No. 104-21, at 9 (discussing murder committed by individual released due to population cap); 141 Cong. Rec S14407, S14418 (daily ed. Sept. 27, 1995) (Sen Hatch).

First, the Order clearly does not satisfy § 3626(a)(1)(A) because it states that the court "ha[s] not evaluated the public safety impact of each individual element of the State's proposed [population reduction] plan." JS2-App 3a; see *id.* at 4a ("Certain of the measures suggested by the state ... were ... not evaluated from the standpoint of public safety."). Moreover, unlike the first population reduction plan submitted by the State, which the three-judge court flatly rejected, the State was unable to attest in its second plan that public safety would be assured Compare *id.* at 32a-33a, with JS1-App 317a & n 1 ("The State ... believe[s] that reducing the prison population to 137.5% within a two-year period cannot be accomplished without unacceptably compromising public safety.") The court nonetheless accepted that plan in the face of clear public safety risks.

Second, the court's assertion that the population reduction measures offered sufficient protections because "they had previously been endorsed by state officials, and thus, presumably, 'would not have an adverse effect on public safety'" cannot withstand scrutiny. JS2-App. 4a (quoting JS1-App 219a), *id* at 3a-4a ("[T]he evidence presented at trial demonstrated that means exist to reduce the prison population without a significant adverse impact on public safety or the criminal justice system.") There is a marked difference between implementing measures under compulsion of a court order and doing so under a time frame chosen (and that can be revisited) by the political branches.

Moreover, the endorsements referenced by the court occurred in 2008 and in budgeting for 2009-2010, see JS1-App 219a, when California's economy was less troubled than it later became. Cf. *id.* at 187a (noting California's "serious fiscal crisis") This is critical because the court conceded that the measures it deemed necessary to ensure public safety will require substantial expenditures by the State or local governments. See, *e.g* , JS2-App. 5a ("additional financial resources from the State [may be required] to ensure that no significant public safety impact results"); JS1-App. 200a (expanded rehabilitation programming would be necessary). It acknowledged that there would be an adverse impact on crime rates without expanded rehabilitation programming for individuals no longer incarcerated by the State JS1-App. 242a. See also *Samson* v *California*, 547 U.S. 843, 850 n.2 (2006) (recognizing that California's parolees present special dangers to the public, recognizing that they "are more akin to prisoners than probationers"), *id* at 853-54 (crediting statistics that 68 percent of adult parolees are returned to prison, 13 percent for the commission of new felonies, and thus "grave safety concerns ... attend recidivism"). Nonetheless, the court presumed that the services necessary to protect the public could be provided, suggesting that "[r]educing the number of persons it imprisons should result in significant savings to the State." JS2-App. 5a; see JS1-App. 187a. Although the court asserted that it was not dictating "whether and to what extent the State should allocate part of its savings" to these programs, JS2-App. 5a, it previously acknowledged that assuring public safety *requires* that the State appropriate funds in this manner. "[T]he proposed population reduction measures would have no adverse effect ... *if the state were to divert some portion of the savings* generated by the population reduction to community corrections, rehabilitation, and re-entry resources" JS1-App. 232a (emphasis added). Compelling the State to divert any such savings in this manner is a severe, unlawful intrusion on the State authority See 18 U.S.C. § 3626(a)(1)(A)

California cannot protect public safety under the order without seriously compromising the ability of its political branches to set the State's priorities. "Federalism concerns are heightened when ... a federal court decree has the effect of dictating state or local budget priorities." *Horne*, 129 S. Ct at 2593-94. "When a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs" *Id.* at 2594. Here, the three-judge court acknowledged that the State already has been forced to "reduce[] spending on education, health care, the social safety net, and services for the needy, the blind, and children to the breaking point." JS1-App. 11a n.4. The release order effectively requires California to spend its money on rehabilitation instead of on improving conditions for the State's citizens. The

PLRA does not allow the court to put California to this choice where, as here, the prisoner release order has not satisfied the requirements that the Act imposes.

The 137.5% cap on the State's general prison population should be set aside.

CONCLUSION

The Court should reverse the judgment for lack of jurisdiction and dismiss the three-judge court. In the alternative, the Court should reverse the judgment of the district court.

Respectfully submitted,

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STATUTORY ADDENDUM

STATUTORY ADDENDUM

FEDERAL STATUTE

18 U.S.C § 3626: Appropriate remedies with respect to prison conditions

(a) Requirements for Relief.—

(1) Prospective relief.—(A) Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless—

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

* * * *

(3) Prisoner release order.—(A) In any civil action with respect to prison conditions, no court shall enter a prisoner release order unless—

(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and

(ii) the defendant has had a reasonable amount of time to comply with the previous court orders.

(B) In any civil action in Federal court with respect to prison conditions, a prisoner release order shall be entered only by a three-judge court in accordance with section 2284 of title 28, if the requirements of subparagraph (E) have been met

(C) A party seeking a prisoner release order in Federal court shall file with any request for such relief, a request for a three-judge court and materials sufficient to demonstrate that the requirements of subparagraph (A) have been met.

(D) If the requirements under subparagraph (A) have been met, a Federal judge before whom a civil action with respect to prison conditions is pending who believes that a prison release order should be considered may sua sponte request the convening of a three-judge court to determine whether a prisoner release order should be entered.

(E) The three-judge court shall enter a prisoner release order only if the court finds by clear and convincing evidence that—

(i) crowding is the primary cause of the violation of a Federal right; and

(ii) no other relief will remedy the violation of the Federal right

* * * *

(g) Definitions —As used in this section—

* * * *

(3) the term "prisoner" means any person subject to incarceration, detention, or admission to any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program,

(4) the term "prisoner release order" includes any order, including a temporary restraining order or preliminary injunctive relief, that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison;

* * * *

APPELLEE'S
BRIEF

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In the
Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, ET AL.,
APPELLANTS,
v.
MARCIANO PLATA AND RALPH COLEMAN, ET AL.,
APPELLEES.

On Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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QUESTIONS PRESENTED

1 Whether the Court's jurisdiction under 28 U.S.C § 1253, which extends only to orders "granting or denying ... an interlocutory or permanent injunction" rendered "by a district court of three judges," authorizes direct review of a single-judge court's decision to convene a three-judge panel, which does not grant or deny injunctive relief

2 Whether the three-judge court clearly erred in concluding that the conditions for a prison overcrowding limit under 18 U S C. § 3626(a)(3)(E) were satisfied based on its fact-intensive determinations (i) that prison overcrowding is the primary cause of California's failure to provide inmates with constitutionally adequate mental and medical healthcare, and (ii) that, in light of numerous unsuccessful previous court orders spanning years of failed remedial efforts, "no other relief" would remedy the ongoing constitutional violations.

3 Whether the three-judge court's order requiring California to reduce overcrowding to within 137.5% of its prisons' total design capacity, while affording state officials broad discretion to choose which remedial measures will safely and effectively address the prison overcrowding crisis, is narrowly drawn, extends no further than necessary, and is the least intrusive means necessary to correct the ongoing violations of inmates' federal constitutional rights.

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JURISDICTION

The Court has jurisdiction under 28 U.S.C. § 1253 to review the three-judge court order granting prospective injunctive relief. Contrary to the State's assertion, the Court lacks jurisdiction to review the single-judge court order granting the request to convene a three-judge court.

STATEMENT OF THE CASE

Every day, psychotic, suicidal, and other severely mentally ill prisoners languish in horrific conditions in California's prisons. Amid what the lead appellant, Governor Schwarzenegger, has proclaimed to be an emergency overcrowding crisis, with acute shortages of staff, hospital beds, and crisis cells, mentally ill prisoners have been found hanged to death in holding tanks where observation windows are obscured with smeared feces, and discovered catatonic in pools of their own urine after spending nights locked in small cages

These grisly examples come not from the original record in this suit, filed twenty years ago, but from the expansive record of current prison conditions during a 2008–2009 trial before a three-judge district court convened under the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626. After a three-week trial, at which dozens of witnesses testified about current prison conditions, the court determined that, until California addresses its unprecedented overcrowding crisis, the State will not be able to resolve the long-standing constitutional violations found by the single-judge district courts in *Coleman v. Schwarzenegger* and *Plata v. Schwarzenegger*. Those courts previously determined that California is not providing its inmates with constitutionally adequate mental health care (*Coleman*) or constitutionally adequate medical care (*Plata*). In fact, California's failure to provide adequate care to seriously mentally ill inmates has persisted through *14 years* of *post-judgment* proceedings. Despite more than 70 previous court orders (*see* Appendix A), remedial plan after plan has been fatally undermined by severe overcrowding. Whatever modest temporary improvements the State may have made, it has failed to remedy the entrenched constitutional violations. And overall conditions are getting worse.

The three-judge court thus required California to take whatever steps it deems necessary to ensure that, within two years, its prison population is within 137.5% of its prison facilities' total design capacity as determined by the State. The court determined that this overcrowding limit is necessary to allow the State to bring its correctional facilities into constitutional compliance. The remedy is expressly authorized under the PLRA, and the court's findings of fact are supported by overwhelming record evidence.

A. The Statutory Scheme

Congress enacted the PLRA to establish standards for entering and terminating prospective relief in civil actions challenging prison conditions. *See Miller v. French*, 530 U.S. 327, 333 (2000). The principal target of the PLRA was long-term structural injunctions that left day-to-day prison management decisions in the hands of federal judges with no end in sight. *See* 141 Cong. Rec. S14,419 (1995) (Sen. Abraham) (the PLRA addresses the problem of "continuous litigation and intervention by the court into the minutiae of prison operations") The statute also addresses "prison release orders" and expressly contemplates that such orders may be required in certain circumstances. 18 U S C. § 3626(a)(3)(A). A "prisoner release order" is a term of art defined expansively to include any order that "has the purpose or effect of reducing or limiting the prison population." *Id* § 3626(g)(4).

A "prisoner release order" may be entered only by a three-judge district court *Id.* § 3626(a)(3). A single judge overseeing a prison case may convene a three-judge court if the single judge finds that (1) a previous order "for less intrusive relief .. has failed to remedy" the constitutional violation, and (2) the defendant has had a "reasonable amount of time" to comply with the "previous court orders." *Id* § 3626(a)(3)(A). In turn, a three-judge court may enter a "prisoner release order" if it finds, by clear and convincing evidence, that (1) crowding is the "primary cause" of the violation, and (2) "no other relief will remedy" that violation *Id* § 3626(a)(3)(E) The order must be "narrowly drawn," "extend[ ] no further than necessary," and be "the least intrusive means necessary to correct" the constitutional violation. 18 U S C. § 3626(a)(1)

B. Failed Efforts To Remedy The Constitutional Violations

1 Twenty years ago, prisoners suffering from serious mental illness (such as schizophrenia, major depression, and bipolar disorders) filed suit because California was failing to provide them with constitutionally adequate mental health care After a contested trial, the district court determined that

the State prison system violated the Eighth Amendment. *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995). It found that California's prisons were "seriously and chronically understaffed", that there were "significant delays in, and sometimes complete denial of, access to necessary medical attention", and that the State lacked a minimally adequate program to identify and treat prisoners with severe mental illness. *Id.* at 1296–97, 1306–15.

2. From 1995 until 2007, the district court tried every conceivable means to prompt the State into ending the constitutional violations. The court issued "well over seventy orders concerning the matters at the core of the remedial process." JS1-App. 38a–39a; *see* Appendix A.[1] It also appointed a Special Master, who over the course of a decade and a half filed 21 monitoring reports and 58 other reports. JS1-App. 36a–38a; J.A. 758–814; *Coleman*-D.E. 3677.

None of these efforts was successful. Although the court's orders initially produced some hard-won progress, inspiring "hopes of eventually ending *Coleman*," the "steadily rising overall population" had caused "earlier gains" to "dissipate[ ]." J.A. 482.

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[1] Cites to "J.A." refer to the Joint Appendix filed by the parties in this case. "JS1-App." refers to appellants' appendix in Case No. 09-416. "JS2-App." refers to appellants' appendix to their Jurisdictional Statement in this case. The district court records in *Coleman*, No. CIV-S-90-0520-LKK (E.D. Cal.) and *Plata*, No. C01-1351-THE (N.D. Cal.) are cited by docket entry (*i.e.* "*Coleman*-D.E. __", "*Plata*-D.E. __"). Trial exhibits are cited by the first letter of the party and by number (*i.e.*, "D-__", "P-__").

By October 2006, California's prisons had reached over 200% of design capacity, and sustained overcrowding had reduced efforts to resolve the constitutional violations into a Sisyphean task. JS1-App. 49a, 60a; *see also* www.rbg-law.com/selected-coleman-plata-trial-materials (website of record materials, including photographs of overcrowded prison conditions).

3. In 2006 and 2007, the Special Master issued reports supporting the conclusion that resources that were "absolutely essential for the provision of adequate mental health services" were "impacted seriously by overcrowding." J.A. 476; *see also* J.A. 2011-2012 (15th Report), 2016-2018 (16th Report). The Special Master found that the lack of space for mental health treatment—clinicians' offices, rooms for interviews, and group treatment facilities—poses a "huge problem." J.A. 479. As the Special Master determined, the State's prison facilities are "hopelessly inadequate" because they are "designed to meet just half of anticipated medical needs"—without any space to accommodate mental health treatment. J.A. 477. Overcrowding made existing problems even more intractable, forcing inmates to spend "larger chunks of their days" in tighter quarters and on lockdown status, "escalat[ing] the incidence of mental illness and exacerbat[ing]" preexisting illnesses. J.A. 479; *see also* J.A. 478 ("growing problems reflect the impact of overcrowding").

The Special Master also found that, after "stalled and ineffectual efforts," whatever progress had been achieved in securing specialized beds for the "most seriously mentally ill" had evaporated due to "severe overcrowding." J.A. 479–480. The shortfall had left large numbers of acutely ill patients with no place for treatment, causing "unmet needs [to] spiral higher and higher." J.A. 481; *see also* J.A. 429 (prison official testifying that lack of mental health beds has reached crisis levels). Because the system does not work, "harassed clinicians often choose not to undertake the frustrating struggle" for bed referrals that often see no action "for weeks or months," further increasing the numbers of psychotic patients "trapped in" outpatient programs "that cannot meet their needs." J.A. 481. Indeed, "nearly 12 years after the determination that mental health services" in California's prisons "were egregiously unconstitutional, hundreds certainly, and possibly thousands" of California's "inmates/patients ... are still looking for beds at the level of treatment their mental illness requires." *Id.*

The Special Master likewise concluded that staffing is an "absolutely essential ingredient" to ending the constitutional violations. J.A. 482. The State increased staffing in the early 2000s, but "the growth of the resource" did not match "the rise in demand" and "earlier gains" dissipated. *Id.* Although the functional vacancy rate for clinicians fell to between 2% and 7% in 2003, by 2007 it had spiked to 20%. J.A. 482–483. And the vacancy rate among top managers reached a "devastating 70%." J.A. 484.

Given the lack of space, beds, and staff, the Special Master found it "easy to conclude" that the key step to fixing ongoing constitutional violations is "a reduction in the overall census." J.A. 486.

"[M]any of the achievements" of the prior decade "succumbed to the inexorably rising tide of population, leaving behind growing frustration and despair" J A 489. The "expanding demand for services resulting from the bulging population" caused such a "deterioration of mental health staffing" that California lacks the "clinical resources" necessary "to meet the needs of some 25 to 30 percent of" mentally ill inmates J.A 2016–2017; J.A 486. The Special Master estimated that an overall reduction of 50,000 prisoners would alleviate persistent staffing shortages, while noting that more clinical staff in specialized mental health units would be required to treat prisoners requiring more intensive levels of care J.A 486–487

4 The State did not object to the Special Master's conclusions *See Coleman*-D.E. 1772, 2067 Nor could it have reasonably done so. California's Governor had already declared a "Prison Overcrowding State of Emergency" *See* Appendix B; J.A 1693–1709. The Governor recognized that "immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding." JS1-App 61a. All 33 of California's prisons "are now at or above maximum operational capacity, and 29 of the prisons are so overcrowded" that more than 15,000 prisoners are being held "in conditions that pose substantial safety risks." *Id.* Overcrowding has overloaded the prison infrastructure. J.A. 1694–1695. Indeed, by the time of the Governor's proclamation, the suicide rate within the prisons had approached "an average of one per week." JS1-App. 61a. The crisis, the Governor declared, "gets worse with each passing

day." *Id.* The Governor's emergency declaration remains in effect.

C. The Decision To Convene A Three-Judge Court

1. In November 2006, following the Governor's emergency declaration, the *Coleman* plaintiffs filed a motion to convene a three-judge court under 18 U.S.C. § 3626(a)(3). The district court held a hearing in December 2006 and granted a six-month continuance, offering the State an opportunity to demonstrate progress and outline measures it would take to improve prison conditions. JS1-App. 63a. That opportunity was wasted.

In June 2007, the district court reconvened proceedings and found that its myriad orders for "less intrusive relief" over the last 12 years had "failed to remedy" the constitutional violations. JS1-App. 65a, 74a, 288a–304a. The court found that California's "mental health care delivery system has not come into compliance with the Eighth Amendment at any point since this action began." JS1-App. 294a. Backsliding had coincided with crisis-level population growth, leading to a 33% rate of "unmet needs" among nearly 33,000 mentally ill inmates. JS1-App. 67a–69a, 296a. The results, the court found, were "unconscionable." *Id.*

2. The State did not contend that it had remedied the constitutional violations. J.A. 446–447. It admitted ongoing deficiencies in mental health care but blamed them on "management issues" and asked for more time. J.A. 1666. The State pointed to plans for prison and jail construction, rehabilitative programs, and parole reforms. JS1-App. 283a, J.A.

458–459, 465–467. But the court found that the State's plans, even assuming they could be timely implemented, would be ineffectual in the face of severe overcrowding. For example, the construction plan, AB 900, authorized the addition of 12,000 new beds by 2009—but the State's own projections showed that it would be short thousands of beds. JS1-App. 300a–301a. Moreover, AB 900 "utterly fail[ed] to address the critical question of staffing," and the State did not explain how it would obtain the additional staff needed to handle the increased prison population. JS1-App 301a, J A 1971. The court found that the State's plan would "aggravate" rather than "alleviate" the problem. JS1-App. 301a

3 With "extreme reluctance but firm conviction," the court determined that a "reasonable time" for compliance had passed, and ordered the convening of a three-judge court JS1-App. 74a, 304a On July 26, 2007, the Chief Judge of the Ninth Circuit convened a three-judge court. JS1-App. 69a. Contrary to the suggestions in its brief, the State raised no objections to the composition of the panel. *See* State Br. 25 nn 7–8.

D. Current Prison Conditions

1. In 2007, the parties began initial discovery into current prison conditions This included undertaking prison tours in which both sides' experts observed housing and treatment areas, reviewed files, and interviewed prisoners, staff, and clinicians *See* J.A. 1863, 1866–1897, J.A. 492–626, 627–691; *Coleman*-D.E 3231-10. In late 2007, the three-judge court stayed discovery and referred the matter to a settlement referee, affording the State another opportunity to avoid judicial intervention JS1-App

69a–70a; *Coleman*-D.E 2620; J.A 1111–1113 These efforts proved unsuccessful.

2 In 2008, plaintiffs sought to resume discovery into current prison conditions. In response, the State sought a protective order *prohibiting* plaintiffs' experts from conducting any further prison tours. According to the State, updated inspections were "irrelevant" and "would constitute a waste of the parties' time and resources" J.A. 1182 In addition, the State filed motions *in limine* to exclude current evidence of staffing shortages, housing conditions, inadequate suicide prevention measures, and inpatient psychiatric hospital bed shortages *Plata*-D E 1559, 1564, 1566, 1576

Over the State's objection, the three-judge court allowed additional expert tours to evaluate current conditions *See* J A. 1864–1865, 1898–1910, J A. 492–626, 692–751, *Coleman*-D.E. 3231-9, 3231-13, 3231-15 The parties acquired extensive information about the current state of California's prisons, analyzing electronically stored information from over 80 state officials and deposing 16 officials with responsibility for overseeing California's prisons.

The State then moved for dismissal and/or summary judgment. *Plata*-D.E 1479 Significantly, the State did not argue that the single-judge courts had not given it sufficient time to comply with previous court orders. *See id.* at 10–16 Plaintiffs opposed both motions and presented overwhelming evidence of continuing constitutional violations. *Coleman*-D E 3054–3061, 3063, 3064

3. On November 3, 2008, the three-judge court denied the State's motion for dismissal and/or for

summary judgment, *see Coleman*-D E 3260, and, on November 10, 2008, denied the motions *in limine* J.A 1688–1690; JS1-App 70a. The court clarified that the PLRA did not authorize it to re-adjudicate the existence of the underlying constitutional violations found by the single-judge courts. If the State wanted to argue that violations no longer existed, it should direct that argument to the single-judge courts and seek relief under Federal Rule of Civil Procedure 60(b)(5) J A. 1691. The three-judge court nonetheless made clear that the parties could introduce evidence of current prison conditions relevant to whether section 3626(a)'s requirements were satisfied, including (1) whether crowding is the "primary cause" of constitutional violations; (2) whether "other relief" will remedy those violations; and (3) the impact of a release order on public safety. *See* J.A 2338–2339.

E. The Three-Judge Court's Findings

The three-judge court held a three-week trial, reviewing hundreds of exhibits and testimony from nearly 50 expert and percipient witnesses JS1-App. 70a On February 9, 2009, the court issued a tentative ruling, finding that plaintiffs had "presented overwhelming evidence that crowding is the primary cause of the underlying constitutional violations." J.A. 1508 The court then waited six months, giving the State another opportunity to avoid judicial intervention. JS1-App. 70a. But the State made no progress and declined to negotiate a settlement.

On August 4, 2009, the three-judge court issued a 183-page opinion and order. The opinion addressed each of the PLRA's statutory requirements, carefully cataloging the evidence and finding that (1) overcrowding is the "primary cause" of the Eighth Amendment violations; (2) "no other relief" will remedy those violations; (3) a 137 5% overcrowding limit is a necessary and narrowly tailored remedy, and (4) the overcrowding limit will not adversely impact public safety JS1-App. 1a–256a

1. Overcrowding Is The Primary Cause Of Ongoing Violations

1 The court accepted the State's argument that "primary cause" in section 3626(a)(3)(E) means "the cause that is 'first or highest in rank or importance, chief, principal" JS1-App 78a. The State did not dispute the notion that overcrowding was *one* cause "imped[ing]" a remedy of these ongoing constitutional violations, the State argued only that overcrowding was not the "primary" cause *Id.* Applying the State's own-proposed definition, the court found that "[t]he only conclusion that can be drawn from the wealth of clear and convincing evidence ... is that the unconstitutional denial of adequate . . mental health care .. is caused, first and foremost, by the unprecedented crowding in California's prisons." JS1-App. 140a–141a, 143a.

2. This determination was well supported Four of the "nation's foremost prison administrators" testified that overcrowding was the primary cause of the continuing constitutional violations. JS1-App. 81a, 141a. The current head of corrections in Pennsylvania, Jeffrey Beard, testified that "the biggest inhibiting factor right now in California being able to deliver appropriate mental health and medical care is the severe overcrowding" JS1-App 82a, 127a–128a. The former head of Texas' prisons,

Doyle Wayne Scott, testified that "[e]verything revolves around overcrowding," which he called the "primary cause of the mental health care violations in California prisons." JS1-App. 127a The former head of corrections in Pennsylvania, Washington, and Maine, Joseph Lehman, testified that crowding is the "primary cause of the inability to provide [mental health] services." *Id.* And the prior head of California's prisons, Jeanne Woodford, testified that overcrowding is "extreme, its effects are pervasive and it is preventing the Department from providing adequate mental and medical health care to prisoners." JS1-App 84a She "absolutely believe[d] the primary cause is overcrowding." JS1-App 126a.

In addition, plaintiffs presented the testimony of Dr. Pablo Stewart and Dr Craig Haney, prominent experts with decades of experience in correctional mental health, who conducted interviews with patients and clinicians, and reviewed patient files at California's prisons in 2007 and 2008. J A. 492–626, 627–691, 692–751. They found that patients are exposed to ongoing risks of injury, death, and inadequate mental health care because the system is "plagued by severe overcrowding" JS1-App 131a–133a The State's own expert, Dr. Ira Packer, who also toured California's prisons in 2007 and 2008, concluded that overcrowding is the primary cause of deficient mental health care in California's prison "reception centers," JS1-App. 138a, and that the State's failure to plan for the number of acutely mentally ill inmates caused inadequacies in the overall system. JS1-App. 138a–139a.

The experts who toured the prisons witnessed symptoms of severe overcrowding, including the conversion of every available space into emergency housing crammed with bunks two and three levels high. The experts observed acutely ill patients held in makeshift spaces such as cages, supply closets, and laundry rooms, awaiting transfer to proper crisis cells. J A. 2090–2092, 2108, 2193; J A. 667–669, J A. 521–525, 541–543, J A. 554–555, 559–560; J A 1880–1881, 1903–1905.

Hard statistics further supported the experts' conclusions that, because of overcrowding, California is unable to provide inmates with adequate mental health care. For example, evidence showed that overcrowding has caused an increasing number of *preventable* suicides. Indeed, not only were the raw numbers of preventable suicides increasing but the suicide *rate* increased to 25.1 per 100,000 inmates—almost double the national average prison suicide rate of 14 per 100,000. JS1-App. 123a; J.A. 1779–1781 Similarly, the percentage of suicides involving "inadequate treatment or intervention" rose sharply from 45% in 2002 to 72.1% in 2006, as overcrowding spiked JS1-App. 124a.

Beyond the statistics, the real-life details of California's prisons are horrific. For example, prison officials referred a 34-year-old suicidal male to a crisis bed but, because no bed was available, he was left in an administrative segregation cell where he hanged himself. J.A. 734–736, 1838–1847 Similarly, two prisoners were placed on suicide watch in "acute psychiatric program unit cells" that had been identified, years before, as needing a simple fix to remove attachment points that could be used to affix a noose *See* J A 1848–1853, 1854–1857, 2317–2319 The retrofits were never performed because they required "remov[ing] inmates from the cells" and there was no place to which to remove them J.A. 2315–2316. Both prisoners hanged themselves J.A 2313–2314.

3 Record evidence also demonstrated that, because of space and staff shortages, overcrowding has caused mentally ill inmates to endure degrading, inhumane, and unconstitutional conditions. The court found that, while waiting for crisis beds, inmates were transferred back and forth between "'dry cells,' which are 'tiny, freestanding upright cages with mesh wiring surrounding them (and no toilet),' during the day" and "'wet cells,' which are holding cells that have toilets, at night." JS1-App. 98a–99a. One prisoner was found "completely unresponsive, virtually catatonic" in a "dry cell," standing in a pool of urine, with a fixed gaze and unable to make eye contact J A. 592–593.

The lack of adequate space to house and treat suicidal inmates has also caused a cascading shortage of space for inmates who are acutely ill but not suicidal. *See* J.A. 2406–2409, 2410–2411; J.A. 1880–1882, 1902–1903. Acutely ill inmates, waiting for transfer to hospital beds, are housed for months in harsh administrative segregation units, isolated and with only limited access to mental health services, a practice that the State's own expert conceded is dangerous and increases the risk of suicide. *Coleman*-D E 3201 at 66–69; J.A 528–539, 550–553, 576–580, 2405–2413. Patients who should be in psychiatric hospital beds remain in crisis beds, causing patients in crisis to remain in housing units where they fail to receive adequate treatment. JS1-App. 122a. The system continues to spiral downward, "intensify[ing] the acuity of mental illness among inmates." JS1-App. 121a. As testimony from State witnesses confirmed, overcrowding is straining the mental health system to a breaking point. *See* J.A. 2324–2325 (shortages of inpatient placements), 2313–2319 (recent suicides in acute mental health unit), 2327–2329 (turning patients away from psychiatric hospital), 2330–2331 (waiting lists), 2333–2336 (efforts to recruit and hire mental health staff), 2341–2342 (unavailability of treatment space), 2344–2347 ("terribly overcrowded" conditions affecting mental health care), 2364–2365 (staffing shortages).

4. Against this clear and convincing evidence, the only evidence the State offered was Dr. Packer's opinion that the primary cause of the ongoing constitutional violations was not overcrowding but rather the State's inadequate planning for the number of acutely mentally ill inmates. JS1-App. 138a–139a. But the three-judge court found that purported distinction illusory. JS1-App. 139a. And even Dr. Packer testified that overcrowding was the primary cause of deficient mental health care at the State's twelve prison "reception centers," JS1-App. 86a, J.A. 1892, which at any given time hold approximately 20% of the total prison population. P-135.

2. No Other Relief Will Remedy The Violations

Having found that overcrowding was the "primary cause" of the ongoing constitutional violations, the court reviewed the State's proposed alternative remedies to determine whether the violations could be "resolved in the absence of" an order limiting overcrowding. JS1-App 145a It found clear and convincing evidence that they could not

1. Several remedies available in theory were unavailable in practice. Constructing new prisons could eliminate overcrowding, but the State "ha[d] not suggested" that it had any plans "to construct additional prisons in the near future" JS1-App. 146a Like the single-judge court, the three-judge court rejected the State's prior construction program, AB 900, as a viable alternative. The State failed to provide funding or necessary legislative fixes for the AB 900 construction program to begin. JS1-App 147a. And, even if funded, designing and constructing new facilities would take many years. JS1-App 147a-151a.

Similarly, the court found that, although hiring additional mental health clinicians might ameliorate some problems, the State "d[id] not suggest" that this would work in practice. JS1-App. 154a Even with more staff, severe space and bed shortages resulting from overcrowding would make it impossible to resolve the constitutional violations JS1-App. 154a-155a Moreover, experience in both *Coleman* and *Plata* had shown that "crowding itself seriously impedes the recruitment and retention" of qualified staff because overcrowding leaves "almost nowhere" for staff to work. JS1-App. 155a.

2. The court also found that maintaining the status quo was not an option. More than a decade of experience with the Special Master and close court intervention had "starkly" demonstrated the

"impossibility" of complying with the Eighth Amendment "at current levels of crowding." JS1-App. 156a-157a. "For almost a decade" the *Coleman* court had "issued specific orders" directed at "each level of the mental health delivery system," but the State was "unable to meet the escalating demand for resources caused by the overcrowding." JS1-App. 157a.

3 Extensive expert testimony further indicated that reducing overcrowding was the only way forward. Dr. Stewart testified that reducing crowding was "the only remedy that would help the system to move into constitutional compliance." J.A. 2517-2518. Secretary Lehman testified that "you cannot provide adequate healthcare and mental healthcare under the current situation of crowding." J.A. 2176. Dr. Beard testified that an overcrowding limit was "the only way" to remedy the inadequacies in mental health care. J.A. 2437. The basic problem, as Director Scott testified, is that California's overcrowding is "unprecedented." JS1-App. 118a (Secretary Lehman: no state "has experienced anything close" to the overcrowding in California). In light of this and other testimony, the court found that "[o]ther forms of relief are either unrealistic or depend upon a reduction in prison overcrowding for their success." JS1-App. 168a.

3. The Remedy Is Narrowly Drawn

The court next found that an overcrowding limit of 137.5% of design capacity was "'narrowly drawn, extend[ed] no further than necessary,'" and was the "'least intrusive means'" to remedy the violation. JS1-App. 169a (quoting 18 U.S.C. § 3626(a)(1)(A)).

1. There was "no serious dispute" that the constitutional violations were "'widespread enough to justify system wide relief.'" JS1-App. 170a-171a (quoting *Lewis v. Casey*, 518 U.S. 343, 359 (1996)). The State had "never contended" that the violations were "institution-specific." JS1-App. 171a. Moreover, a single system-wide limit was less intrusive than a "series of institution-specific caps." *Id.* Although institution-specific relief "would be tailored to each institution's needs and limitations," it "would interfere with the [S]tate's management of its prisons more than a single systemwide" overcrowding limit, which left the State with flexibility "to continue determining the proper population of individual institutions." *Id.*

The court emphasized that an overcrowding limit did *not* require the State to "throw open the doors of its prisons." JS1-App. 173a-174a. Rather, the State could "choose among many available means of achieving the prescribed population reduction." JS1-App. 174a. The order thus "maximiz[ed] the [S]tate's flexibility and permitt[ed] the [S]tate to comply" with the overcrowding limit "in a manner that best accords with the [S]tate's penal priorities." *Id.*

2. The court found ample support for the 137.5% limit. Plaintiffs had come forward with extensive evidence supporting a 130% limit, JS1-App. 179a-180a, introducing "strong evidence that a prison system operating at even 100% design capacity will have difficulty providing adequate medical and mental health care to its inmates." JS1-App. 176a-179a, 183a. (A prison with every bed filled is already "overcrowded" for purposes of mental

health treatment because there is no flexibility to make necessary transfers.) Plaintiffs drew the 130% figure from "the Governor's own prison reform personnel"—a Facilities Strike Team established to combat the declared overcrowding prison emergency. JS1-App 179a That Team, after an independent review, set a "long-term goal" of 130% of design capacity *Id.* Directors Lehman, Scott, and Woodford testified in support of the 130% limit, stating that it was a "realistic and appropriate" maximum. JS1-App 180a.

To be sure, as the State emphasizes, the Governor's hand-picked panel determined in 2004 that California's maximum "operable capacity" was 145%. State Br. 44–45, J.A. 1761–1763; JS1-App. 181a–182a, J A. 752–754 (testimony of the review panel's principal consultant) But the 145% ceiling "did not account for programming associated with mental health or medical treatment" or the long history of entrenched constitutional violations JS1-App. 182a, J A. 746–749. The 145% figure was thus too high

3. The State complains that the 137.5% limit is unsupported, but the State did not present "any evidence or arguments suggesting that [the court] should adopt a percentage other than 130% design capacity." JS1-App 175a Although the court asked the parties to submit evidence and argument about an appropriate percentage, the State refused. J A. 2555. Accordingly, because the State did not present any evidence regarding the maximum population at which it could comply with the Eighth Amendment, the court was left with undisputed evidence that the population "*must* be reduced to some level between

130% and 145% design capacity" JS1-App 183a. The court chose 137 5%, "a population reduction halfway between the cap requested by plaintiffs and the warden's estimate of the California prison system's maximum operable capacity absent consideration of the need for medical and mental health care." JS1-App. 184a That limit was more forgiving than the only proposal by a party (130%), and was at the outer limit supported by any record evidence

4. The Remedy Poses No Adverse Impact On Public Safety

1 The court devoted ten days of trial—and 50 pages of its opinion—to considering the impact the proposed overcrowding limit would have on "public safety or the operation of [the] criminal justice system" 18 U.S C. § 3626(a)(1)(A). It was undisputed that the State had several means to address overcrowding without releasing prisoners· It could construct additional prisons, transfer inmates to prisons in other states, divert mentally ill patients away from prison, or implement sentencing reforms (*e g* , "adjusting the threshold value at which certain property crimes become felonies to reflect inflation since 1982"), as the Governor has proposed. JS1-App. 219a.

The key to the court's safety finding was what it did *not* order a "generic early release" of prisoners. JS1-App. 196a The court specifically noted that a "sudden mass release of one-third of California's prisoners or a ban on accepting new or returned prisoners" would affect public safety JS1-App 222a But "[t]hat approach was not proposed by any party, nor would it be approved by the court." *Id.*, *see also* JS1-App. 193a–194a

2. The court found that the record evidence "clearly establishe[d]" that the State could comply with the overcrowding limit without having an adverse impact on public safety. JS1-App. 188a–189a. There was "overwhelming agreement among experts for plaintiffs, defendants, and defendant-intervenors that it is 'absolutely' possible to reduce the prison population in California safely and effectively." JS1-App. 192a–193a (quoting J.A. 2511 (defendant-intervenor's corrections expert)); *see also* J.A. 2488 (State expert), J.A. 2495 (Secretary Lehman); J.A. 2423 (Secretary Woodford).

Record evidence showed that at least three measures would reduce overcrowding without adversely affecting crime rates. *First*, the State itself had "proposed the expansion of earned good time credits." JS1-App. 197a. In fact, "[e]xperts presented by plaintiffs, defendants, and defendant-intervenors all supported the expansion" of the State's existing "good time credits" system. JS1-App. 196a.

Second, the State's own prison officials and experts "overwhelmingly supported" ending California's "abnormal" practice of putting *all* offenders on "parole" after they complete their sentences—without any risk assessment—and re-imprisoning them for technical parole violations. JS1-App. 204a, 208a. (In California, "parole" is a misnomer, and parolees are more analogous to federal "supervised releasees" who have not benefitted from any traditional discretionary "parole" before completing their sentence. *See* J.A. 1772–

1776. State officials testified that changes in parole revocation practices, as used in Pennsylvania, South Carolina, New Jersey, Oregon, Georgia, Iowa, Kansas, South Dakota, and Texas, would reduce both the prison population and crime JS1-App 206a–207a

Third, State law enforcement officials testified that diverting low-level offenders to community correctional programs, rather than prison, could improve public safety. In Secretary Woodford's words, "'California would have safer communities if it used such [community-based] sanctions rather than incarceration in appropriate circumstances'" JS1-App 211a (quoting *Coleman*-D.E. 3231-15)

3 The court also found that the State could improve public safety through "evidence-based rehabilitative programming—*i e*, programs that research has proven to be effective in reducing recidivism" JS1-App. 214a. This finding was uncontroverted "*Every witness,* from [the State's] Undersecretary of Programming to law enforcement officers and former heads of correctional systems," testified that an increase in the availability of such programs "would reduce the prison population and have a positive impact on public safety." *Id* (emphasis added).

Moreover, contrary to the State's assertions, *see* State Br. 8, 10, 54–56, the court did not find that such rehabilitative programs were necessary to avoid an increase in crime. Quite the opposite. The court expressly stated that, "[e]ven if the [S]tate were not" to implement rehabilitative programs, "population reduction could be accomplished without any significant adverse impact on public safety." JS1-App. 187a.

4. The evidence showed a proven track record for safely implementing overcrowding limits. Secretary Lehman testified that Washington reduced prison populations through the same techniques available to California—expanding good time credits, reducing imprisonment for technical parole violations, and instituting graduated sanctions—without having any "'deleterious effect on crime.'" JS1-App. 243a–244a (quoting J.A. 2489–2490, 2491–2492, 2493–2494). Dr. Beard similarly testified that Pennsylvania used evidence-based programming, graduated sanctions, and parole reform to reduce prison populations while "improv[ing] public safety." JS1-App. 244a. And empirical studies showed that population reductions had been implemented without adversely affecting public safety in Colorado, Florida, Illinois, Indiana, Kansas, Maryland, Michigan, Montana, Nevada, New York, Ohio, Texas, Washington, and Wisconsin. JS1-App. 244a–245a.

In light of this "overwhelming" evidence, the court found a 137.5% limit appropriate. The State's penal policies had contributed to a 750% increase in prison population since the 1970s, but the State's "political decision-makers" had failed "to provide the resources and facilities" required to satisfy the bare constitutional minimum of mental health care. JS1-App. 254a. The courts had "proceed[ed] cautiously" for more than a decade, but "the political process has utterly failed to protect the constitutional rights" of mentally ill inmates. JS1-App. 254a-255a. As a result "the courts can, and must, vindicate those rights." JS1-App. 255a.

F. The Remedial Order and Appeal

The court gave the State 45 days to propose an overcrowding reduction plan to meet the 137.5% limit within two years. The State appealed to this Court and sought a stay, which was denied. *See California State Republican Legislators v. Plata*, 130 S. Ct. 1142 (2010), *Schwarzenegger v. Plata*, 130 S. Ct. 1140 (2010), *Schwarzenegger v. Coleman*, 130 S. Ct. 46 (2009). The State's first remedial plan was rejected by the three-judge court as woefully noncompliant. *Coleman*-D.E. 3711. Then, in November 2009, the State submitted a revised plan. JS2-App. 25a–70a. That plan incorporates many elements—including good-time credit earning enhancements, re-entry courts, and parole reforms for low-risk offenders—that are required under recently enacted state prison reform legislation (Senate Bill 18) and the State's own experts and officials had previously endorsed as *improvements* to public safety. JS1-App. 196a–216a, 319a–327a, 340a–341a.

On January 12, 2010, the three-judge court entered a final order accepting the State's second proposed plan. JS2-App. 1a–10a. Reiterating that it did not "intervene lightly in the State's management of its prisons," JS2-App. 9a, the court held that it would not mandate any specific measures in the State's plan—affording the State "maximum flexibility" to decide which options would best achieve constitutional compliance. JS2-App. 3a. The court emphasized its "hope that California's leadership will act constructively and cooperatively . . . so as to ultimately eliminate the need for further federal intervention." JS2-App. 9a. The court stayed its order pending review by this Court, affording the

State an additional year to meet the overcrowding limit.

On January 19, 2010, the State appealed the three-judge court's January 2010 order as well as the single-judge court's decision to convene a three-judge court. On June 14, 2010, this Court granted review, while deferring the jurisdictional question concerning the State's challenge to the single-judge court's decision.

SUMMARY OF ARGUMENT

California's prisons are in the midst of an unprecedented, entrenched overcrowding crisis that is threatening the lives of thousands of mentally ill inmates and preventing the State from providing those inmates with the basic humane care required by the Eighth Amendment No one can reasonably dispute that, as Governor Schwarzenegger has declared, California's prisons are overwhelmed by an overcrowding emergency. Nor has the State ever made any showing that it has resolved the long-standing constitutional violations, despite more than 70 previous court orders and numerous iterations of failed remedial plans spanning two decades of litigation. The three-judge court made extensive fact-findings about current conditions, correctly determined that the PLRA's requirements were satisfied, and ordered the State to take whatever steps it deems necessary to ensure that, within two years, prison overcrowding is reduced to within 137.5% of its prisons' total design capacity

The State seeks to litigate arguments that were forfeited below and to sweep aside the lower court's factual findings with heavy reliance on extra-record evidence But it has made no showing that the lower court's factual findings are clearly erroneous. The State instead seeks to manufacture legal issues based on a strained interpretation of the PLRA The State's proposed interpretation is inconsistent with the statute's plain terms If this extraordinary case does not warrant relief under the PLRA, it is hard to fathom any situation where the PLRA's expressly contemplated remedy of a "prisoner release order" would be appropriate.

The State contends that the single-judge court improperly convened the three-judge court because it purportedly failed to afford the State reasonable time to comply with its latest remedial order. But the Court has no jurisdiction to consider that argument, because its jurisdiction under 28 U.S.C § 1253 extends only to orders granting or denying an injunction rendered by a three-judge court In any event, the single-judge court did not convene the three-judge court until long after the Governor himself had proclaimed an overcrowding emergency and did so only after making detailed findings that the State had failed to comply with more than 70 orders spanning more than a decade, and determining that the State's latest proposals for addressing the constitutional violations were not viable solutions, but more of the same

The State next contends that the three-judge court's overcrowding limit is inappropriate because the court purportedly did not consider current prison conditions or require overcrowding to be the "primary cause" of the entrenched constitutional violations But that is not true Over the State's *objections*, the court below considered and relied on extensive evidence of current prison conditions Moreover, applying the *State's* own proposed definition of "primary cause"—as the "first or highest in rank or importance"—the three-judge court found that overcrowding was the primary cause of the ongoing, entrenched constitutional violations, and that absent a limit on overcrowding, the State will not be able to remedy the violations. The court's findings are supported by substantial record evidence and the State has made no showing that they are clearly erroneous.

Finally, relying on arguments forfeited below, the State contends that the overcrowding limit is not narrowly tailored and threatens public safety But the three-judge court explained in detail the reasons the overcrowding limit was appropriate, and provided the State with flexibility and discretion to implement the programs it desires and to allocate resources as it sees fit. The State has made no showing that any of the options it has selected to address the overcrowding crisis will cause any threat to public safety. To the contrary, as the three-judge court determined, the ongoing, entrenched overcrowding crisis is responsible for preventable deaths and poses its own serious threats to public safety.

ARGUMENT

I. The State's Position Rests On A Distorted View Of The PLRA And This Court's Precedents.

It is hard to imagine where the PLRA's expressly contemplated remedy of a "prisoner release order" would ever be appropriate if the extraordinary and egregious facts, history, and circumstances of this case do not warrant the relief ordered here. The State nonetheless urges the Court to interpret the PLRA's provisions in a manner that would effectively strip federal courts of authority to grant necessary relief where, as here, the entrenched constitutional violations are at their worst. The Governor himself has declared an overcrowding emergency. *See* Appendix B. And the courts have confirmed not just entrenched constitutional violations, but the unnecessary loss of human life. The State pays no heed to the broader consequences of its position. Nor does it make any attempt to reconcile its position with this Court's settled precedents concerning the role of federal courts and the deference afforded to lower court fact-finding. At least three fundamental flaws pervade the State's arguments.

1. *First,* the Court should reject the State's suggestions, made in various guises, that the PLRA's provisions should be interpreted as effectively extinguishing the ability of federal courts to grant appropriate relief when dire constitutional violations require intervention. *Bowen v. Michigan Acad. of Family Physicians*, 476 U.S. 667, 681 n.12 (1986) (Congress "cannot bar all remedies for enforcing federal constitutional rights") (citation omitted). There is a critical difference between reserving

overcrowding limits as a remedy for intractable constitutional problems (as Congress did) and eliminating such orders as a viable remedy (as the State urges) The former raises few difficulties, the latter implicates separation-of-powers concerns of the first order.

As this Court has recognized, absent the "clearest command," Congress should not be assumed to restrict the equitable powers of the federal courts *Holland v Florida*, 130 S Ct 2549, 2560 (2010) (citation omitted). The "essence" of a court's equity power "lies in its inherent capacity to adjust remedies in a feasible and practical way to eliminate the conditions or redress the injuries caused by unlawful action," and "equitable remedies must be flexible if these underlying principles are to be enforced with fairness and precision" *Freeman v Pitts*, 503 U.S 467, 487 (1992) Rather than take a necessary remedy off the table, there is thus every reason to interpret the PLRA's provisions as written—not to prohibit orders directed at overcrowding, but to reserve such orders for the rare case (like this one) where the remedy of last resort is necessary

There is no dispute that the PLRA establishes certain requirements that must be satisfied before a court enters an order that "has the purpose or effect of reducing or limiting the prison population" 18 U.S C. § 3626(g)(4) But Congress did not erect insurmountable barriers to granting effective relief where extensive proceedings prove that prisoners continue to be exposed to life-threatening inadequacies in basic mental health care, and the State itself concedes that its prisons remain in an emergency "overcrowding crisis." JS1-App 61a. To the contrary, Congress plainly intended that, in these circumstances, federal courts would have authority to impose appropriate equitable relief. *See* H.R. Rep. No. 104-21, at 25 (1995) (a "court still retains the power to order" population reduction when it "is truly necessary to prevent an actual violation of a prisoner's federal rights"). The Court should reject the State's strained interpretation that, instead of limiting federal courts' exercise of equitable authority, would effectively eliminate that authority altogether. Congress has substantial authority, but it may not render federal courts powerless to remedy life-threatening constitutional violations.

2. *Second*, the Court should recognize that the remedy ordered by the court below is more consistent with federalism principles than the State's preferred alternatives. The PLRA was intended to establish a process that allows a federal court to take assertive action in egregious cases to remedy constitutional violations once and for all. It cabins that authority by ensuring that, once the constitutional violations are remedied, the court must end its supervision and promptly restore control over the prisons to local officials. *See* 18 U.S.C. § 3626(b) (establishing procedures for terminating relief). But the thrust of the Act is to prevent perpetual structured injunctions that take prison administration away from accountable, elected officials.

The order here is the antithesis of the detailed structural injunctions micro-managing every aspect of prison administration that were the principal target of the PLRA. Instead, the order provides the

State with "maximum flexibility" to decide how best to address the overcrowding crisis and put itself on a path to remedying its long-standing constitutional violations. Indeed, the order is striking for what it does not require: *It does not mandate the release of any prisoner or require that the State adopt any particular remedial measure.* The State may select any mix of options that it deems appropriate to address the overcrowding crisis, including constructing new facilities, transferring prisoners out-of-state or to private prisons, mandating that short sentences be served in county jails, or improving rehabilitative programming. By requiring the State to make these choices, the order promotes transparency and helps ensure that state officials will be held accountable for the decisions they make for running California's prisons. *See Frew v. Hawkins*, 540 U.S. 431, 442 (2004).

In contrast, the State urges the federal courts to double-down on a decades-long pattern in which the State's repeated failures to fix prison conditions required ever more-specific direction from the federal courts—a pattern doomed to failure by the State's proven inability to address the primary cause of the crisis conditions and the primary obstacle to remedying the constitutional violations: out-of-control overcrowding. In urging the Court to jettison the three-judge court's order, the State is seeking to extend remedies that would further blur the lines of accountability, leaving the federal courts, but not the State, responsible for making the difficult decisions required to fix California's broken prison system. That approach would allow the State to oppose needed reforms and complain that federal courts are micromanaging California's prisons, while still failing to take steps necessary to address the ongoing constitutional violations.

As this Court has recognized in other contexts, there are "powerful incentives" that lead state officials to oppose injunctive relief that requires transparency and accountability. *New York v. United States*, 505 U.S. 144, 182 (1992). Indeed, state officials may well "prefer the supervision of a federal court to confronting directly its employees and the public." *United States v. Miami*, 2 F.3d 1497, 1507 (11th Cir. 1993). Rather than responding to the "priorities and concerns of their constituents," especially in circumstances where developing "solutions to problems of allocating revenues and resources" has been made difficult by years of neglect, state officials may prefer to leave the business of running the prisons under the supervision of the federal courts, even while life-threatening prison conditions continue to sink far below minimally humane standards and the structural problems that make the constitutional problems intractable go unaddressed. *Horne v. Flores*, 129 S. Ct. 2579, 2594 (2009) (citing *Frew*, 540 U.S. at 442). Nowhere is this temptation likely to be greater than in a state like California, where long-entrenched fiscal problems make it tempting to blur lines of accountability rather than face and make hard choices.

3. *Third*, the Court should reject the State's repeated attempts to re-litigate the existence of the underlying constitutional violations. Although the State tries to manufacture a few legal disputes, most of which were forfeited below, what the State really seeks is to re-litigate the facts. Those facts were

found by the lower courts in two full trials (the 1994 *Coleman* trial and the 2008 *Coleman/Plata* trial), as well as numerous evidentiary and motion hearings, and resulted in scores of failed remedial orders and unfulfilled plans that preceded convening the three-judge court. This Court should not engage in its own appellate fact-finding based on arguments that were forfeited below. *See Icicle Seafoods, Inc. v. Worthington*, 475 U.S. 709, 714 (1986) (discussing problems of appellate fact-finding)

The three-judge court's order includes extensive and detailed findings that support its order for injunctive relief. Those findings provide the factual basis for the court's determinations that overcrowding is the primary cause of the ongoing, entrenched constitutional violations, and that no other appropriate relief will remedy those violations. On page after page of its brief, however, the Governor's lawyers rely on selective citations to the record and extra-record evidence in an attempt to convince this Court that California's prisons are not in the continuing state of emergency declared by the Governor himself. But the State cannot rely on extra-record evidence, and it has made no showing that any of the facts found by the lower court are "clearly erroneous." *Anderson v. Bessemer City*, 470 U.S 564, 574 (1985).

Similarly, although the State repeatedly touts purported improvements in California's prisons and suggests that the long-standing constitutional violations are not as dire as the courts found and the evidence establishes, the State has never pursued readily available avenues for seeking appropriate relief If circumstances really have changed, the proper approach is not for this Court to interpret the PLRA in a strained fashion based on new fact-finding undertaken for the first time on appeal *See Cutter v Wilkinson*, 544 U S. 709, 718, n.7 (2005) ("we are a court of review, not of first view"). Instead, the proper remedy is for the State to seek relief under Rule 60(b)(5) Under this Court's settled precedents, lower courts apply a "flexible approach" and will modify injunctions when circumstances have significantly changed and the ordered injunction is no longer needed to remedy constitutional violations. *See Horne*, 129 S. Ct. at 2584 As this Court has recognized, prospective relief under the PLRA "is subject to the continuing supervisory jurisdiction of the court" and may be modified under Rule 60(b)(5) in appropriate circumstances *Miller*, 530 U S. at 347–48.

II. The Single-Judge Court's Decision To Convene A Three-Judge Court Was Correct And Is Not Reviewable Under 28 U.S.C. § 1253.

The State argues that the three-judge court lacked jurisdiction because it was purportedly convened before California had "a reasonable amount of time" to comply with previous court orders *See* State Br 20–24. That issue is not properly before the Court. And, in any event, the State's fact-based objection is meritless.

A. The Decision To Convene A Three Judge Court Is Not Properly Before The Court.

1. Under 28 U S.C § 1253, this Court's appellate jurisdiction is limited to orders "*granting*

or denying . an interlocutory or permanent injunction in any civil action, suit or proceeding required .. to be heard and determined *by a district court of three judges* " 28 U S C § 1253 (emphases added). A decision to convene a three-judge court does not satisfy the statutory prerequisites because it is neither an order "granting or denying" injunctive relief nor a determination made by a "district court of three judges." *Hicks v. Pleasure House, Inc.*, 404 U.S. 1, 2 (1971).

2. The Court's section 1253 jurisdiction is "narrowly" construed *In re Slagle*, 504 U S. 952, 952 (1992) (White, J., concurring) ("we narrowly view our appellate jurisdiction in three-judge court cases") It extends only to "orders actually entered by three-judge courts," *Gonzales v Automatic Employees Credit Union*, 419 U.S 90, 97 n 14 (1974), and only to orders that rest "upon resolution of the merits" of the underlying constitutional claim. *MTM, Inc. v. Baxley*, 420 U.S 799, 804 (1975). This construction is consistent with "the historic congressional policy of minimizing" the Court's "mandatory docket ... in the interest of sound judicial administration " *Id.*

The Court has thus held that when a three-judge court is improperly convened, the court is entitled to dissolve itself—a decision that is reviewable only in the court of appeals. *See Mengelkoch v Industrial Welfare Comm'n*, 393 U S. 83, 83 (1968); *Wilson v. City of Port Lavaca*, 391 U S 352, 352 (1968); *see also McLucas v. DeChamplain*, 421 U.S. 21, 30 (1975) (orders denying three-judge panel appealable only to court of appeals) Any issues short of the merits—including "justiciability, subject-matter jurisdiction, equitable jurisdiction, and abstention"—

are not subject to this Court's review on "direct appeal" *Gonzalez,* 419 U S at 295. Non-merits issues must be reviewed in the first instance by a court of appeals *Id* [2]

3. The State fails to engage in any meaningful analysis of the Court's authority to review a single-judge court's order. Instead, the State addresses jurisdiction in a single sentence, citing *Gully v Interstate Natural Gas Co* , 292 U.S. 16 (1934) *See* State Br 24. By presenting essentially no argument on the issue, the State forfeits its position *See Joint Stock Soc'y v UDV N America, Inc* , 266 F 3d 164, 178 n.9 (3d Cir. 2001) (Alito, J).

In any event, *Gully* cannot bear the weight the State places on it. That decision predates this

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[2] In earlier briefing, the State asserted that plaintiffs' position on this issue has changed because plaintiffs moved to dismiss the State's appeal to the Ninth Circuit as premature *See* Opp to Mot To Dismiss or Affirm at 3 In fact, plaintiffs have consistently maintained that the orders referring *Coleman* and *Plata* to the three-judge court were subject to review in the court of appeals at the appropriate time and pursuant to the appropriate vehicle In 2007, plaintiffs successfully argued that the appellate court lacked jurisdiction because no final decision had issued, the orders were not immediately appealable under the collateral order doctrine, and the State had not taken the steps necessary to perfect its appeal, by either waiting for a final judgment, pursuing an interlocutory appeal under 28 U S C § 1292(b), or petitioning for a writ of mandamus *See* Mot To Dismiss at 11–15, No 07-16361 (9th Cir Aug 20. 2007), *cf Mohawk Indus , Inc v Carpenter*, 130 S Ct 599, 607 (2009) ("several potential avenues of review" for non-final orders) Plaintiffs never argued that the State could bypass those legitimate avenues of review and appeal the district courts' referral orders directly to this Court

Court's authoritative interpretations of the statute making clear that preliminary issues decided by a single-judge court are properly reviewed in the courts of appeals Moreover, *Gully* is part of a line of decisions that granted discretionary review because the time for appeal had expired and "the correct procedure" for seeking review of the single-judge court's order was not "definitely settled at the time the appeal to this Court was attempted." *Oklahoma Gas & Elec. Co v Oklahoma Packing Co.*, 282 U.S 386, 392 (1934) (had "correct procedure" been clear, it would be proper to dismiss the appeal); *Phillips v. United States*, 312 U S 246, 251 (1941) (same). *Gully* was not purporting to determine whether the PLRA's specific provisions were satisfied—a fact-intensive inquiry as to whether a defendant has had "reasonable" time to comply with previous court orders. Instead, *Gully* determined that the three-judge statute was wholly inapplicable as a threshold matter of law 292 U S at 18

The PLRA's structure is different from other statutes that contemplate the use of three-judge courts, because convening a three-judge court under the PLRA does not divest the single-judge court of jurisdiction over the underlying cause of action. Instead, the PLRA is a remedial statute that imposes additional procedures that must be satisfied before injunctive relief may be granted in the context of prison litigation 18 U.S C § 3626; *cf. Jones v Bock*, 549 U.S 199, 212 (2007) (PLRA's exhaustion requirement is an affirmative defense, not a jurisdictional prerequisite to suit). Because only the remedy question, not the entire cause of action, is before the three-judge court, it makes sense that this

Court's review is limited to considering only the merits of the three-judge court's remedial order

The State here does not argue that section 1253 is inapplicable Nor can it claim that the "correct procedures" for seeking review to the court of appeals are unclear. In these circumstances, the Court lacks jurisdiction to consider whether the single-judge courts properly decided to convene the three-judge court

B. The Courts Below Afforded The State A "Reasonable Amount Of Time" To Comply With Previous Court Orders.

The prudence of not revisiting the single-judge court's decision to convene a three-judge court back on a date certain over three years ago is underscored by the Court's ability to review a clearly related and far more relevant question. whether the three-judge court's ultimate remedial order was fatally premature. Although this Court lacks jurisdiction to consider whether the three-judge court was properly convened, it plainly has jurisdiction to determine whether, at the time of the three-judge court's "prisoner release order," the State had been given reasonable time to comply with previous court orders. 18 U S.C. § 3626(a)(3)(A)(ii) ("no court shall enter a prison release order unless ... the defendant has had a reasonable amount of time to comply with the previous court orders") The State never addresses this issue because it strains credulity to suggest that the three-judge court acted prematurely. When the single-judge court convened the three-judge court in July 2007, the State had already proclaimed an overcrowding emergency and had been given 12 years to comply with previous court orders Even if that were somehow not a reasonable amount of time, the three-judge court afforded the State an additional two years of time to correct the entrenched constitutional violations As the three-judge court properly recognized, the State still had not complied with the previous court orders by the time the court entered its "prison release order" on August 4, 2009. The State is not entitled to any more time

1 Through the course of this decades-long litigation, the State has been afforded more than reasonable time to end its life-threatening constitutional violations. When plaintiffs moved to convene the three-judge court, the single-judge court stayed the matter for six months and sought input from the Special Master, who reported that the few areas of improvement had "succumbed to the inexorably rising tide of population." J.A. 489. Only then did the district court convene the three-judge court That decision was neither unreasonable nor precipitous. And it was supported by extensive findings of fact. The single-judge court provided a detailed description of its reasons for concluding that the State had failed to comply with more than 70 previous orders and that the State's latest plans for compliance were not viable. *See* JS1-App. 291a–297a.

2. The State has not even attempted to show that the single-judge court abused its discretion in determining that the State was afforded reasonable time to comply with previous court orders. Instead, it contends that the court "mistakenly interpreted the PLRA to allow three-judge proceedings so long as the State had been given a reasonable amount of

time to comply with *any* prior remedial order " State Br 13. Not so The court never held that it was enough that reasonable time had elapsed since any single order. It held that "reasonable time" had passed since the State had failed to comply with the "orders of this court" issued "through the present," including the latest order in 2006 JS1-App 296a–297a.

The State's position rests on a strained reading of the statutory requirements *See* State Br. 16 In the State's view, even though it failed to cure the constitutional violations notwithstanding "well over seventy orders concerning the matters at the core of the remedial process" over the span of 12 years, JS1-App. 38a–39a, and was in the midst of a self-proclaimed emergency, it should have been given more time to comply with the very *last* of the district court's remedial orders According to the State, the clock for convening the three-judge court restarts with each new order.

The State's reading of the statute is untenable. *See Hartford Underwriters Ins Co v. Union Planters Bank, N A*, 530 U S. 1, 9 (2000) (party seeking to avoid "most natural reading" of a statute bears an "exceptionally heavy" burden) (citations omitted). Contrary to the State's suggestions, a single judge court is not required to cease issuing remedial orders and allow serious constitutional violations to fester before convening a three-judge court This is especially true given the reality that a judge that determines that a situation with unremedied constitutional violations has reached extremes may well need to issue separate orders addressing the exigency before convening a three-judge court *See*

Miller, 530 U S at 355, 357 (Breyer, J , dissenting) (typical that a single-judge court attempting to resolve constitutional violations will have entered a "complex system of orders entered over a period of years") So, for example, the appointment of a receiver and the convening of a three-judge court could be related responses to a system having reached a breaking point, rather than discrete orders that must be separated by a discrete interval

If Congress had intended the decision to convene a three-judge court to turn on only the last remedial order issued by the single-judge court, it could have phrased the statutory language to indicate that intent and would not have referred to "the previous court orders" in the plural *See Gwaltney of Smithfield, Ltd. v Chesapeake Bay Found , Inc.*, 484 U.S 49, 57 (1987) (Congress's failure to "choose this readily available option" in phrasing statutory language confirms that proposed reading is implausible) Indeed, under the State's interpretation, it is illogical for Congress to have referred to "previous court orders" in section 3626(a)(3)(A)(ii), because the only relevant order on the State's view is the most recent order issued by the single-judge court

Interpreting the PLRA as preventing a court from ever convening a three-judge court as long as the single-judge court continues to issue remedial orders also cannot be reconciled with the Court's long-standing recognition that the "opaque terms and prolix syntax" of the PLRA should not be given an impractical interpretation. *Gonzalez*, 419 U.S. at 97. Nor can it be reconciled with the bedrock principle that, absent an especially clear statement of congressional intent, a statute should not be construed to restrict the equitable powers of federal courts *Miller*, 530 U.S at 336 The State's approach requires concluding that Congress intended to tie the judiciary's hands in precisely those cases where relief is most urgently needed—namely, in cases where prison systems are in the worst condition and district court judges have issued multiple orders seeking to correct ongoing and entrenched constitutional violations *Cf Martin v. Hadix*, 527 U S 343, 354 (1999) ("it stretches the imagination to suggest that Congress intended through the use of this one word" to apply statute retroactively).

3 In any event, the State was afforded more than reasonable time to comply with previous orders The 2006 orders referenced by the State were part of a succession of (unsuccessful) escalating measures imposed since 1997. That the single-judge court continued to issue remedial orders as late as 2006 is not a sign that the State had inadequate time to comply; instead, it is proof the court's previous orders were not working and the district court was diligent in exhausting alternatives As the district court explained, the State had been given more than sufficient time "to comply with the mandate required by the court's 1995 order *and the numerous orders issued since then* " State Br. 22 (emphasis added).

4. The State points to its December 2006 mental health bed plan as purported evidence to the contrary. *See* State Br 21–22 n.5 But that plan was abandoned, the State even asked the district court and Ninth Circuit to rule that the medical and

mental health construction on which it was based was unlawful. *See* Tr 1688–90.

The State also contends that recent purported "improvements" in California's prison system suggest that, with more time, the court's latest remedial orders would have prompted the State to correct the constitutional violations. But most of the improvements represent aspirational plans, not concrete results And the district court's decade-plus experience with this case made it appropriately skeptical of grandiose plans to remedy conceded constitutional violations. Moreover, the State's assertion was not only rejected by the single-judge court, but also by the three-judge court, which found that no other relief could remedy the constitutional violations without requiring the State to address its overcrowding crisis The State has made no attempt to show that those findings are "clearly erroneous." Fed R Civ. P. 52 Nor has the State ever filed a Rule 60(b)(5) motion or made any showing that the underlying constitutional violations are sufficiently remedied to obviate the need for further relief The overwhelming evidence shows, and the State's judicial admissions confirm, that life-threatening constitutional violations persist because of the intolerable overcrowding crisis. *See* J.A. 821–824 (2010-04-14 order finding rising rate of preventable suicides), 863–868 (high rate of suicides in 2010)

5 Finally, the State asserts in passing that if a three-judge court "was inappropriate in either proceeding," the Court should reverse because it "cannot meaningfully review the merits of the three-judge court's order arising out of the combined cases." State Br. 25. That is not correct. The three-

judge court's order makes findings that separately address the current, ongoing violations in the delivery of mental health care from the current, ongoing violations in the delivery of medical care. *See* JS1-App 30a–52a (failure to remediate mental health care), 90a–91a (failures of mental health screenings), 97a–100a (dangerous shortages of mental health placements), 103a–104a (effect of non-traditional housing on mentally ill inmates), 108a–109a (mental health staffing), 112a–114a (psychotropic medication), 118a (effect of constant lockdowns on mental health care), 121a–123a (increase acuity of mental illness due to overcrowding), 123a–124a (overcrowding major cause of lapses in mental health care in suicide cases), 130a–133a, 137a–140a (testimony of expert psychologists and psychiatrists whose investigations were conducted independently from medical experts). It also includes separate findings regarding the feasibility of "other relief." *See* JS1-App. 154a, 156a–158a, 164a–168a (testimony and evidence on overcrowding control as prerequisite to other remedies) Accordingly, even if the State should have been given more time to comply with the previous orders in *Plata*, the mentally ill inmates in *Coleman* should not be required to wait any longer before action is taken to remedy the continuing constitutional violations *See Johnson v Manhattan R. Co*, 289 U S. 479, 497 (1933) (consolidation for convenience does not merge suits into a single cause).

III. The Three-Judge Court's Remedial Order Complies With The PLRA.

The State contends that the three-judge court "misinterpreted" the PLRA's requirements State Br 30. There is no merit to these contentions. In a detailed opinion the three-judge court explained why the PLRA's requirements were satisfied

A. The Order Complies With 18 U.S.C. § 3626(a)(3)(E).

Under 18 U S C. § 3626(a)(3)(E), a court may order prospective relief when (1) overcrowding is the "primary cause" of the violation of federal rights, and (2) "no other relief" will remedy that violation Contrary to the State's assertions, the court correctly applied both requirements and its factual findings are entitled to deference.

1. The Court Properly Applied The "Primary Cause" Requirement.

1 The State begrudgingly acknowledges that the three-judge court accepted—*verbatim*—its own definition of "primary cause." State Br 32. It was undisputed at trial that "primary cause" is defined as the "first or highest in rank or importance; chief; principal." *See* State Br. 32, JS1-App. 78a. The State nonetheless offers two new definitions of "primary cause," which it urges the Court to consider. Because they were not pressed below, these arguments are forfeited. *See Sprietsma v Mercury Marine*, 537 U S. 51, 56 n 4 (2002).

In any event, neither proposed definition can withstand scrutiny. The State first posits that "primary cause" means "'but for' and 'proximate' causation" State Br. 31. Recognizing that "the

PLRA ... did not define 'primary cause,'" that "the legislative history is silent," and declaring Congress's references to the term "in other contexts ... not helpful here," the State asserts that a "but-for" definition would generally promote "the PLRA's intent to make prisoner release the remedy of last resort." State Br. 30-31. But that outcome-driven reading is neither compelled by the text; nor is it a prerequisite to being the "first or highest" cause. It is also contrary to the long line of precedents that, while acknowledging occasional overlap between the two concepts, carefully distinguish "primary" and "proximate" cause. *See N.Y. Cent. R.R. Co. v. White*, 243 U.S. 188, 205 (1917) (act "disregards the proximate cause and looks to one more remote,—the primary cause"); *United States v. Hatfield*, 591 F.3d 945, 949 (7th Cir. 2010) (Posner, J.) (equating primary and proximate cause "confuses things"). Nor does the State's criticism of a "contributing cause" test justify a "but-for cause" test; that strawman is beside the point because the three-judge court never relied on a "contributing cause" test.

The State also defines "primary cause" as a cause whose elimination "undo[es] all or virtually all of the constitutional harm." State Br. 33. That stringent standard is not supported by a single citation because it is a creature of the State's own imagination. It also makes no sense. It would mean that no remedy could issue unless the court simultaneously resolved every deficiency at once, rendering the courts' remedial powers their weakest in addressing egregious prison conditions where the courts' powers are needed the most.

2. Nor does the State's proposed definition take into account the broader statutory structure In the context of a provision that the State itself submits is reserved for exceptional cases when alternatives have been exhausted, interpreting primary cause to mean but-for cause makes little sense. The statute clearly seeks reassurance that overcrowding is the primary cause for the persistence of the constitutional violations, or the primary obstacle to eliminating the entrenched constitutional violations. Here, there is no doubt that this requirement is satisfied The three-judge court adhered to the State's own undisputed definition of "primary cause" and—with 46-pages of detailed fact-finding—found it satisfied Clear and convincing evidence showed that severe overcrowding was the "first and highest" cause of horrific, inhumane conditions, including deteriorating mental health care, increasing spread of infectious diseases, unnecessary deaths, and preventable suicides.

3 The State does not dispute that overcrowding is *a cause* of the violations. The State also does not dispute that overcrowding is the *primary cause* of at least some violations. *See* J A 2402-2403, 2557–2558; JS1-App. 138a. Nor does the State make any showing that the facts found by the three-judge court are clearly erroneous The State instead picks at the margins. It alleges, for example, that the court insufficiently considered "evidence concerning the current status of alleged Eighth Amendment violations" State Br 27.

In fact, however, the three-judge court grounded its order in updated evidence. *See, e g*, JS1-App. 85a–95a (space findings based on 2007–2008 tours);

JS1-App. 93a (space findings based on November 2008 analysis of deaths); JS1-App 97a–98a (mental health crisis bed shortages based on 2008 reports); JS1-App 98a–99a (alternative crisis placement findings based on 2007 and 2008 suicides), JS1-App 101a (testimony on non-traditional beds as of trial); JS1-App. 108a (mental health staffing data from 2007–2008); JS1-App 111a (custodial staffing data from 2008), JS1-App. 113a–114a (findings of psychotropic medication system failures based on 2008 data). Although the three-judge court rejected attempts to re-litigate the underlying constitutional violations, it made clear that evidence of current prison conditions would be considered "to the extent that it illuminates questions that are properly before the court." J.A. 2338–2339 As the State's counsel recognized, there is a critical distinction between re-trying the single-judge case and "inform[ing] the [three-judge] court of exactly the impact of overcrowding on the mental health services delivery system" both in the past and "as the population exists today." *Id.*

Contrary to the State's suggestions, it was not barred from presenting evidence from either the *Coleman* Special Master or the *Plata* Receiver In fact, the three-judge court ordered the Receiver's most current report, including 15 items requested by the State, entered into evidence. J.A. 1194–1198 The State itself made extensive use of the Special Master's updated reports, even though it never sought discovery from the Special Master or listed him as a witness. Although it opposed the 2008 prison inspections, the State ultimately sent its experts to inspect the prisons, and they offered testimony on current prison conditions *See* J.A.

2395–2413, 2414–2420 The State likewise presented testimony regarding current medical and mental health expenditures, staffing, and results, J.A 2289–2301, 2302–2336, 2339–2377, presumably because most of plaintiffs' evidence addressed the current state of California prisons' medical and mental health care. *See* J.A. 2087–2109, 2185–2205, 2229–2287

Less than six weeks before trial, the evidence was current. In response to the State's own request, the three-judge court set a discovery cut-off and limited plaintiffs' ability to tour the prisons after August 30, 2008 *See* J.A. 1683–1684, J A. 1188–1193. The State never moved to update the evidence of current conditions after the close of evidence and before the court's final judgment

2. The Court Correctly Concluded That "No Other Relief" Would Remedy The Ongoing Violations.

1 The State also disputes the determination that "no other relief" would remedy the longstanding constitutional violations, listing alternative measures to which it claims the court gave short shrift. State Br. 36–40 But, here again, the State makes no showing of clear error Moreover, characterizing construction, hiring, the Special Mastership, and transfers as *alternative* remedies misses the point. Nothing in the overcrowding limit precludes the State from utilizing any or all of those tools

More fundamentally, these are the same tools that the State has unsuccessfully employed in its attempts to remedy the constitutional violations for more than a decade. The three-judge court thus determined that none of these alternatives would work unless overcrowding was first addressed. JS1-App. 145a–168a, *see also* 18 U.S.C. § 3626(a)(3)(E)(ii). It had already delayed the matter for more than a year, from the convening orders in July 2007 through the commencement of trial in November 2008, during which the State again tried and again failed to apply the same set of tools. The court thus reasoned that overcrowding, as the "first and highest" cause of the constitutional violations, had to be addressed. Nothing in the State's extended discussion of tentative gains detracts from that conclusion.

2. The State complains that the three-judge court insufficiently credited its commitment to construct more facilities. But the court relied on clear and convincing evidence that the State could not build itself out of the problem in any reasonable time-frame commensurate with the emergency conditions. JS1-App. 145a–154a. Because "the [S]tate could, in theory, always build more prisons," JS1-App. 146a, the more relevant question was the State's ability to follow through on "actual, feasible, sufficiently timely" construction plans. JS1-App. 146a, 153a–154a.

The State's own witnesses testified that the plans it offered at trial—the Receiver's plan for dedicated healthcare facilities, and AB 900's prison construction plan—would not work. Although the State counted the Receiver's plan as part of its strategy to fix overcrowding, *see* Tr. 1688–90, it actively blocked funding for the project and the plan was subsequently scrapped. *See* JS1-App. 150a–

151a Similarly, AB 900, the 40,000 bed construction program the State once touted as the overcrowding solution, had already failed by the time of trial. The State voted to deny the money necessary to build the beds, *see* Tr 1689–90, and preliminary construction planning had not even begun. J A 755; P-750; *see also* J A. 756–757 Eight months after trial, AB 900 remained unfunded and construction had not begun on a single new facility. JS1-App 147a, 150a

Instead of addressing the evidence presented at trial, the State focuses on its latest in a long line of ineffectual construction plans. But even the latest plan the State cites will, by its own concession, not be completed until 2014 at the earliest. The State's claim that new facilities "will begin accommodating inmates this year" is thus tentative and vague for good reason Building projects and funding efforts have repeatedly been proposed and repeatedly stalled, on October 19, 2010, the State filed its latest delay notice, informing the single-judge *Coleman* court that the 2,840-bed centerpiece of its new mental health building plan has been indefinitely delayed by the legislature. J A. 873–883. This is just the latest instance of the legislative intransigence that the Governor himself lamented in his emergency proclamation back in 2006 *See* Appendix B The court did not clearly err in holding that the latest proposed construction plans would not obviate the necessity of an overcrowding limit

3. The State also invokes "positive" trends on the staff hiring front, singling out certain goals met by the *Plata* Receiver. *See* State Br 37–38 But those steps in the right direction hardly undermine the court's judgment that hiring reforms would have

limited success absent an overcrowding fix Indeed, the *Coleman* court had issued staffing orders for years, and the Special Master reported that modest gains were overwhelmed by overcrowding JS1-App. 295a–296a. It was thus reasonable to conclude that lasting and truly significant hiring gains were unrealistic without more space JS1-App 154a–155a.

4. The State also suggests that the convening of the three-judge court somehow interrupted a veritable "surge" by the Special Master. *See* State Br. 20–24 But his efforts were also swallowed up by the overcrowding crisis *See* JS1-App. 49a (noting "troubling reversal in the progress of the remedial efforts" and "profound impact of population growth"); JS1-App 52a, 142a, 155a–159a, 303a; J.A 489 Expert testimony likewise indicated that "tentative progress" had been "overwhelmed by the massive population expansion" despite "more than ten years of intensive monitoring and other remedial efforts" J A 743–744, 2195–2196.

5 Finally, the State asserts that it could solve the overcrowding crisis by transferring prisoners out of state. But out-of-state transfers is not "other relief" because it too constitutes a "prisoner release order" under the PLRA JS1-App 159a n 58 Moreover, the State contends that the court below "reject[ed] the possibility." State Br. 39. That overstatement has no bearing in fact. Far from "block[ing]" transfers, the single-judge court issued one order—at the Special Master's urging—limiting the transfer of *seriously mentally ill* prisoners due to inadequate mental health services. That order set no limits on the number of prisoners that California

may transfer out-of-state J A 435 Indeed, the State has steadily increased its use of out-of-state prisons, where it now houses almost 10,000 prisoners The State has offered no basis to dispute the court's conclusion that the State's transfer proposals were "too small to significantly affect the provision of medical and mental health care to California's inmates" JS1-App 160a And, in all events, nothing stops the State from employing increased out-of-state transfers to comply with the overcrowding limit

B. The Court's Order Complies With 18 U.S.C. § 3626(a)(1)(A).

The State argues that the overcrowding limit violates the PLRA because it is insufficiently "narrowly drawn" and gives inadequate consideration to "public safety." 18 U S C § 3626(a)(1)(A). But the court struck a careful balance between enforcing the "basic ... minimally adequate" standards required by the Eighth Amendment, while refraining from undue interference with the State's prerogatives Indeed, even though the overcrowding limit may be deemed a "prisoner release order" under the PLRA, *see* 18 U.S C § 3626(g), the limit does not mandate the physical release of any prisoners Instead, the court—considering the State best-positioned to make judgments as to its budget priorities and public safety—allowed the State to choose whatever combination of measures would be most effective, safe, and financially feasible to resolve the overcrowding crisis and the ongoing constitutional violations

1. The Overcrowding Limit Has An Obvious Nexus To The Ongoing Violations.

1 The State's brief tries to sow confusion by questioning the nexus between the overcrowding limit and ongoing constitutional violations. But given the more than 14 years of remedial proceedings and 70 court orders that preceded this appeal, the State should not be allowed to rewrite history Even the Intervenors' expert concurred that "the necessary constitutional medical and mental health services can't be provided with today's overcrowding " J A. 2516, *see also* J.A 2511–2512

Whatever the inevitable line-drawing difficulties that arise when imposing an overcrowding limit, a line must be drawn. There is no "exact science" to that line, as the court duly recognized *See* JS1-App 175a. But when the three-judge court justified the 137 5% limit, it did so based on the evidence at trial—not some utopian vision of what would "prove beneficial" as a matter of policy State Br. 47 The State never challenged the 137 5% number The court credited recommendations of a 130% cap by the State's construction manager, the Governor's own prison reform personnel, and current and former heads of prison systems in five states And upon finding that a 130% limit would "comport[] with the PLRA," it raised the limit to 137 5% to afford the State greater flexibility. JS1-App 169a

2 The State's allusions to "design capacity" and "double-celling" are distractions The State has conceded that California's prisons were not built to provide adequate medical and mental health care above 100% design capacity. *See* JS1-App 56a–58a;

D-1007 ¶ 72; J A 2349–2350, 2419–2420 And California's prison overcrowding is widely recognized as a radical outlier. *See* JS1-App 78a (experts reporting "almost unheard of" levels of overcrowding), J.A 2111–2112, 2174–2177, 2181–2182, 2186–2189 (same). In any event, neither "double-celling" nor the percentage overcapacity are themselves constitutional violations. Rather, the violations involve the adjudicated failure to provide constitutionally adequate medical and mental health care to inmates—and the primary cause of those intractable violations is overcrowding.

3. The State's suggestion that the limit is overbroad because it should have targeted only class members represents another shift in position At trial, the State rejected relief focused solely on the classes, arguing that the three-judge court should *exempt* mentally ill prisoners from any population reduction order. JS1-App 236a. As the State no doubt recognized, a class-members-only mandate would restrict the pool of prisoners who could be assessed and impair the State's flexibility to account for whether prisoners are high- or low-risk, which prisoners warrant transfers or parole, and so forth. *Cf.* JS1-App. 224a. The State thus submitted a plan that elected to reduce the prison population for the benefit of low-risk prisoners. JS1-App. 312a–353a; *see also* JS1-App 175a (deferring to "state expertise" to limit judicial intrusion into "minutiae of prison operations"). And that system-wide relief makes sense because the underlying violations are systemic deficiencies Mentally ill inmates are not limited to specific facilities, nor likely to remain in one facility for long periods of time. The critical scarce resources—inpatient psychiatric beds, short-term

crisis beds, and sheltered housing—are shared among California's prisons on a regional and statewide basis. JS1-App 41a–42a. Even a prison that may have capacity to treat patients at low levels of care becomes a place of grave danger when an inmate whose condition worsens must wait months or even years to transfer to a higher level of care. JS1-App. 45a–47a, 97a–100a.

4. Ultimately, the 137.5% overall benchmark gives the State maximum flexibility consistent with federalism principles in redressing the constitutional violations. *See Missouri v. Jenkins*, 515 U.S. 70, 98 (1995). The overcrowding limit allows the State to balance population pressures at different institutions based on facility-specific discretionary judgments.

The State attempts to downplay its discretion by pointing to a single-judge order regarding a now-abandoned plan to retrofit a dilapidated former juvenile prison into what would have been the largest prison mental health outpatient unit in the State. State Br. 53, *Coleman*-D.E. 3734 at 3, J.A. 825–828, 858–861. But that now-moot order concerned specific conditions in one project, for a highly specialized mental health population. And it left unaltered the flexibility that the three-judge court's order leaves the State over the *entire prison system*. The three-judge court expressly declined to interfere with the management of individual prisons, ordering a system-wide overcrowding limit that "permits the [S]tate to continue determining the proper population of individual institutions." JS1-App 171a. And rather than micromanage the State's financial resources, the court's order allows the State to draw from any tools it wishes and acknowledges that the benchmarks would not remain “static” JS2-App. 4a–6a For example, if the State were to build or contract for new facilities, that “increase in design capacity through construction would decrease the number of inmates by which the prison population must be reduced.” *Id*

That the State nonetheless complains of harms to “federalism” and the “separation of powers” to ward off the court’s remedy comes as little surprise State Br 49–53. That move is consistent with the State’s long-standing efforts to shield itself from accountability Rather than assume responsibility for remedying the violations, the State has for years “not taken .. seriously” its inhumane prison conditions, shifted blame, and resisted the hard choices that a constitutional remedy necessarily entails J A. 1815. Serious federalism concerns do not credibly hang in the balance when the State arguably enjoyed even less discretion under the specific court mandates issued over the course of a decade California cannot further prolong its foot-dragging on devising a solution for the widespread violations of its inmates’ constitutional rights. The State’s suggestion that the court “usurped the role of the political branches” rings hollow, State Br 48, when the very basis of the order is to stir the political branches from their longstanding inaction.

2. The Overcrowding Limit Serves The Interests Of Public Safety.

1. The State’s contention that the three-judge court disregarded public safety is wrong. The court examined hundreds of exhibits related to public safety and devoted nearly ten days of trial. JS1-App. 185a The State itself represented that it could

"safely reach a population level of 137.5%" of design capacity. JS1-App. 317a. The Governor, in presenting his proposal to the State legislature, has declared that a reduction of 37,000 prisoners could be accomplished safely in two years. *See* J.A. 1522–1524; *see also* J.A. 2559–2561. The court thus appropriately found that the State could "comply with [the] population reduction order *without a significant adverse impact upon public safety*." JS1-App. 187a (emphasis added).

2. The State did not bring forth any evidence below of the public safety concerns it now emphasizes. The State notes that, unlike its first plan, in its *second* plan, the State omitted a sentence vouching that the plan would comport with public safety. State Br. 54. But deleting that single sentence has all the hallmarks of an empty litigation tactic. If the State believes there is a public safety threat posed by any of the choices it has made to address prison overcrowding, it should have stepped forward and substantiated its concern to the court below. It is up to the State to select among the various options it put forth in its plan and, if necessary, to bring issues to the attention of the three-judge court. JS2-App. 4a–5a.

Moreover, as the court suggested, the State's substantial savings from a manageable prison population could be redirected towards "rehabilitative and reentry programming in the prisons" and community re-entry programs, which have been shown to *promote* public safety. JS1-App. 187a, 235a. Drawing on that suggestion, the State contends that the order below seeks to "dictat[e]" its budget priorities. State Br. 55. But the three-judge court's order affords the State broad discretion to implement the programs it desires and to allocate its resources as it sees fit.

3. Dozens of other jurisdictions throughout the country have safely implemented reductions in prison and jail populations without seeing increases in recidivism or crime. JS1-App. 202a–203a, 243a–246a. Similarly, numerous county jails in California have released prisoners (without endangering public safety) to maintain capacity around or below 100% due to safety concerns and/or court-imposed overcrowding limits. JS1-App. 224a–227a & n.84, 202a–203a. During a decade of operation from 1996 through 2006, such local overcrowding limits in California did not result in a higher crime rate. JS1-App. 203a. California's unprecedented overcrowding crisis is an outgrowth, in part, of its distinct criminal laws and parole system, which put thousands in prison who would not be there at all in other states. Should the State elect to change its system, empirical evidence shows no significant risk of public harm. JS1-App. 243a–246a.

4. Finally, the continuing constitutional violations, resulting from inundated prison facilities themselves, pose a serious threat to public safety. Prison staff cannot operate effectively in such overcrowded conditions. And there is a reasonable societal expectation that individuals should suffer condign punishment for the crimes they commit without facing the additional risk of untreated severe illness or death in prison.

* * *

The three-judge court's narrowly tailored order, which holds state officials accountable by requiring them to decide how to address California's emergency overcrowding crisis, complies with the PLRA. This is an unusual order, but this is an unusual case. After 20 years of continuing constitutional violations that, despite more than 70 previous court orders, the State has failed to remedy, the State should not be allowed to further delay taking actions to address overcrowding that it concedes can be safely implemented in two years. And the State has not even attempted to demonstrate that any of the lower courts' factual findings are clearly erroneous. When Congress enacted the PLRA, it expressly contemplated that there would be circumstances where a "prisoner release order" is required when other efforts to remedy constitutional violations have failed. If the remedy of an overcrowding limit is not appropriate in this extreme case, it is hard to imagine any case where the PLRA would apply.

CONCLUSION

The Court should affirm the decision below.

Respectfully submitted,

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APPENDIX

TABLE OF APPENDICES

Appendix A

Previous Court Orders That Have Failed To Remedy The Ongoing Constitutional Violations App-1

Appendix B

Proclamation — State of Emergency in California Department of Corrections and Rehabilitation (October 3, 2006). App-10

Appendix A

Previous Court Orders That Have Failed To Remedy The Ongoing Constitutional Violations

1. 1996-02-07 Order [Docket # 659] (timelines for Special Master to complete key projects)
2. 1996-05-09 Order [Docket # 693] (concerning Special Master powers)
3. 1996-07-12 Order [Docket # 710] (Special Master powers)
4. 1997-01-30 Order [Docket # 795] (plans, policies, and procedures)
5. 1997-06-27 Order [Docket # 858] (Program Guide accepted and monitoring of implementation to begin)
6. 1998-05-21 Order [Docket # 945] (adding specialized treatment beds, access to Department of Mental Health hospital beds)
7. 1998-06-16 Order [Docket # 948] (clinical staffing, use of force, discipline, involuntary medication, screening, administrative segregation)
8. 1998-08-12 Order [Docket # 964] (clinical staffing, quality assurance and peer review)
9. 1998-08-25 Order [Docket # 968] (clinical staffing, discipline, and use of force)
10. 1998-10-08 [Docket # 978] (clinical staffing, compensation)

11. 1998-11-19 Order [Docket # 991]
(deficiency plans for seven specific prisons concerning multiple issues)

12. 1998-12-09 Order [Docket # 1003]
& 1999-01-19 Order [Docket # 1010]
(clinical staffing)

13 1999-04-09 Order [Docket # 1021]
(access to care in administrative segregation, clinical staffing)

14 1999-07-23 Order [Docket # 1054]
(amending plaintiff class, suicide prevention, deficiency at specific prison, access to higher levels of care)

15. 1999-07-26 Order [Docket # 1055]
(clinical staffing, access to care in administrative segregation and general population, transfers to higher levels of care, suicide prevention, use of force and discipline, training of clinical and custodial staff)

16. 1999-12-09 Order [Docket # 1097]
(clinical staffing, compensation)

17. 1999-12-21 Order [Docket # 1101]
(custody staffing)

18 2000-01-13 Order [Docket # 1111]
(clinical staffing, recruitment and retention, compensation)

19. 2000-02-10 Order [Docket # 1132]
(deficiencies at specific prison)

20. 2000-02-22 Order [Docket # 1135]
(status of mental health programs at specific prison with remedial plan)

21. 2000-04-27 Order [Docket # 1155]
(recruitment and retention plans for clinical staff, requiring reports on departure of psychiatrists, clinical staffing)
22. 2000-07-03 Order [Docket # 1176]
(timelines for transfers of mentally ill to higher levels of care)
23. 2000-08-28 Order [Docket # 1195]
(access to higher levels of care including Department of Mental Health hospitalization)
24 2000-08-28 Order [Docket # 1198]
(clinical staffing, recruitment, and retention, compensation)
25 2000-09-14 Order [Docket # 1201]
(access to care, specialized treatment beds at higher levels of care, timelines for transfer to higher levels of care)
26. 2000-12-22 Order [Docket # 1229]
(suicide prevention, reports on employee discipline and plan for improved access to crisis beds)
27. 2001-04-04 Order [Docket # 1262]
(clinical staffing, recruitment and retention, transfer timeline, and study to determine adequacy of number of specialized beds for higher levels of care)
28. 2001-06-27 Order [Docket # 1278]
(deficiencies at specific prisons for various issues, tracking of transfers to higher levels of care, construction report, access to Department of Mental Health inpatient beds)

29. 2001-10-01 Order [Docket # 1306]
(suicide prevention and implementing suicide reporting policy)

30 2001-10-26 Order [Docket # 1309]
(staffing ratios for segregation units and deficiencies at specific prisons)

31. 2001-12-20 Order [Docket # 1323]
(adding sufficient specialized treatment beds at all levels of care, programming space for administrative segregation units, disciplinary process for mentally ill prisoners, deficiency at specific prison)

32 2002-04-09 Order [Docket # 1367]
(study of high security intensive outpatient care inmates, access to Department of Mental Health inpatient beds, discharges from such beds, deficiencies at specific prison, adding specialized treatment beds)

33. 2002-04-25 Order [Docket # 1372]
(deficiencies at specific prison)

34 2002-05-07 Order [Docket # 1375]
(adding specialized treatment beds and planning for inpatient hospital bed needs)

35 2002-06-13 Order [Docket # 1383]
(clinical staffing, recruitment and retention)

36. 2002-06-13 Order [Docket # 1384]
(plans for deficiencies at specific prisons, medication management, clinical staffing, administrative segregation)

37. 2002-07-26 Order [Docket # 1398]
(clinical staffing vacancies and state hiring freeze)

38 2002-10-08 Order [Docket # 1431]
(adding specialized treatment beds, deficiencies in specific prisons, access to Department of Mental Health beds, state budget process)

39. 2002-10-2 Order [Docket # 1440]
(order restricting housing of inmates with mental illness in new stand-alone administrative segregation units)

40. 2002-12-09 Order [Docket # 1478]
(reentry planning for mentally ill prisoners)

41. 2003-07-25 Order [Docket # 1536]
(clinical staffing, recruitment and retention, compensation, medication management, suicide prevention, access to Department of Mental Health inpatient beds)

42 2003-10-20 Order [Docket # 1548]
(access to necessary levels of care and proposed closure of Department of Mental Health program)

43. 2004-01-12 Order [Docket # 1559]
(clinical staffing, administrative segregation, delays in transfers to higher levels of care, study of unmet inpatient bed needs, suicide prevention,)

44. 2004-07-09 Order [Docket # 1594]
(study of unmet inpatient bed needs, access to higher levels of care)

45. 2004-07-27 Order) [Docket # 1598]
(plans for deficiencies at specific prisons)

46 2004-10-05 Order [Docket # 1607]
(study of unmet needs for inpatient beds)

47. 2004-10-29 Order [Docket # 1624]
(access to necessary levels of care, deficiency at specific prison, licensing of inpatient beds)

48 2005-01-27 Order [Docket # 1638]
(adding specialized treatment beds, access to Department of Mental Health beds)

49 2005-03-08 Order [Docket # 1654]
(clinical staffing, deficiencies at specific prisons, access to higher levels of care)

50 2005-06-10 Order [Docket # 1667]
(deficiency at specific prison, clinical staffing and recruitment plans)

51 2005-06-10 Order [Docket # 1668]
(requiring cell modifications, emergency life support for suicide prevention)

52 2006-03-03 Order [Docket # 1772]
(clinical staffing, recruitment and retention)

53 2006-03-03 Order [Docket # 1773]
(Revised Program Guide adopted and implemented)

54. 2006-03-09 Order [Docket # 1774]
(deficiency at specific prison, clinical staffing)

55. 2006-05-02 Order [Docket # 1800]
(adopting defendants' long term bed plan to add specialized treatment beds, ordering emergency short and intermediate projects, access to Department of Mental Health beds, state licensing issues)

56. 2006-05-02 Order [Docket # 1802]
(access to Department of Mental Health beds and adding Director as party defendant)

57. 2006-05-02 Order [Docket # 1803]
(enhanced access to necessary levels of care in reception centers)

58 2006-06-08 Order [Docket # 1830]
(suicide prevention plan for administrative segregation units)

59 2006-06-28 Order [Docket # 1855]
(Department of Mental Health Director as party defendant)

60. 2006-07-20 Order [Docket # 1904]
(adding emergency specialized treatment beds and waiving state law and regulations)

61. 2006-08-01 Order [Docket # 1929]
(adding state director of finance as official capacity defendant)

62 2006-08-23 Order [Docket # 1962]
(access to Department of Mental Health beds)

63 2006-10-20 Order [Docket # 1998]
(population projection process for future needs for specialized treatment beds and plan for construction of necessary specialized beds, emergency short and intermediate term construction projects, access to higher levels of care, acceleration of construction projects)

64 2006-11-06 Order [Docket # 2025]
(screening for transfers to out of state prisons)

65 2006-12-15 Order [Docket # 2083]
(clinical staffing, compensation)

66. 2007-01-25 Order [Docket # 2119]
(coordination of Special Master and Plata Receiver, and other prison class actions)

67 2007-02-12 Order [Docket # 2139]
(adding specialized treatment beds)

68 2007-03-01 Order [Docket # 2154]
(additional emergency beds and treatment space at specific prisons)

69 2007-03-09 Order [Docket # 2156]
(access to necessary levels of care and specialized bed shortage)

70 2007-03-12 Order [Docket # 2157]
(discipline and use of force)

71 2007-03-12 Order [Docket # 2158]
(access to higher levels of care, access to Department of Mental Health beds, tracking of delays in transfers to higher levels of care, administrative segregation)

72 2007-03-27 Order [Docket # 2173]
(adding specialized treatment beds, deficiencies at specific prisons, relationship with Department of Mental Health)

73 2007-03-28 Order [Docket # 2178]
(adding specialized treatment beds)

74. 2007-04-17 Order [Docket # 2200]
(access to necessary levels of care, long term construction plans, relationship with Department of Mental Health)

75. 2007-05-23 Order [Docket # 2236]
(clinical staffing, access to Department of Mental Health beds, compensation and clinical staffing for Department of Mental Health)

76. 2007-05-23 Order [Docket # 2237]
(access to necessary levels of care, Department of Mental Health beds)

77. 2007-06-28 Order [Docket # 2301]
(clinical staffing, compensation for Department of Mental Health clinicians, access to care)

Appendix B

Prison Overcrowding
State Of Emergency Proclamation

PROCLAMATION
October 4, 2006

PROCLAMATION

by the

Governor of the State of California

WHEREAS, the California Department of Corrections and Rehabilitation (CDCR) is required by California law to house inmates committed to state prison; and

WHEREAS, various trends and factors, including population increases, parole policies, sentencing laws, and recidivism rates have created circumstances in which the CDCR is now required to house a record number of inmates in the CDCR prison system, making the CDCR prison system the largest state correctional system in the United States, with a total inmate population currently at an all-time high of more than 170,000 inmates, and

WHEREAS, due to the record number of inmates currently housed in prison in California, all 33 CDCR prisons are now at or above maximum operational capacity, and 29 of the prisons are so overcrowded that the CDCR is required to house more than 15,000 inmates in conditions that pose substantial safety risks, namely, prison areas never designed or intended for inmate housing, including, but not limited to, common areas such as prison gymnasiums, dayrooms, and program rooms, with approximately 1,500 inmates sleeping in triple-bunks, and

WHEREAS, the current severe overcrowding in 29 CDCR prisons has caused substantial risk to the health and safety of the men and women who work inside these prisons and the inmates housed in them, because:

With so many inmates housed in large common areas, there is an increased, substantial risk of violence, and greater difficulty controlling large inmate populations.

With large numbers of inmates housed together in triple-bunks, there is an increased, substantial risk for transmission of infectious illnesses.

The triple-bunks and tight quarters create line-of-sight problems for correctional officers by blocking views, creating an increased, substantial security risk.

WHEREAS, the current severe overcrowding in these 29 prisons has also overwhelmed the electrical systems and/or wastewater/sewer systems, because those systems are now often required to operate at or above the maximum intended capacity, resulting in an increased, substantial risk to the health and safety of CDCR staff, inmates, and the public, because:

Overloading the prison electrical systems has resulted in power failures and blackouts within the prisons, creating increased security threats. It has also damaged fuses and transformers.

Overloading the prison sewage and wastewater systems has resulted in the discharge of waste beyond treatment capacity, resulting in thousands of gallons of sewage spills and environmental contamination.

And when the prisons "overdischarge" waste, bacteria can contaminate the drinking water supply, putting the public's health at an increased, substantial risk.

WHEREAS, overloading the prison sewage and water systems has resulted in increased, substantial risk of damage to state and privately owned property and has resulted in multiple fines, penalties and/or notices of violations to the CDCR related to wastewater/sewer system overloading such as groundwater contamination and environmental pollution, and

WHEREAS, overcrowding causes harm to people and property, leads to inmate unrest and misconduct, reduces or eliminates programs, and increases recidivism as shown within this state and in others, and

WHEREAS, in addition to all of the above, in the 29 prisons with severe overcrowding, the following circumstances exist:

Avenal State Prison has an operational housing capacity of 5,768 inmates, but it currently houses 7,422 inmates, with 1,654 inmates housed in areas designed for other purposes At the same time, in the last year, there were 64 incidents of assault/battery by inmates—31 of them against CDCR staff—along with 15 riots/melees, and 27 weapon confiscations

The California Correctional Center has an operational housing capacity of 5,724 inmates, but it currently houses 6,174 inmates, with 450 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 128 incidents of assault/battery by inmates—16 of them against CDCR staff—along with 34 riots/melees, and 21 weapon confiscations.

The California Correctional Institution has an operational housing capacity of 4,931, but it currently houses 5,702 inmates, with 771 inmates housed in areas designed for other purposes At the same time, in the last year, there were 125 incidents of assault/battery by inmates—79 of them against CDCR staff—along with 5 riots/melees, and 57 weapon confiscations.

Centinela State Prison has an operational housing capacity of 4,368, but it currently houses 4,956 inmates, with 588 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 141 incidents of assault/battery by inmates—30 of them against CDCR staff—along with 10 riots/melees, and 151 weapon confiscations.

The California Institution for Men has an operational housing capacity of 5,372, but it currently houses 6,615 inmates, with 1,243 inmates housed in areas designed for other purposes At the same time, in the last year, there were 170 incidents of assault/battery by inmates—57 of them against CDCR staff—along with 21 riots/melees, and 47 weapon confiscations

The California Institution for Women has an operational housing capacity of 2,228, but it currently houses 2,624 inmates, with 396 inmates housed in areas designed for other purposes At the same time, in the last year, there were 65 incidents of assault/battery by inmates—26 of them against CDCR staff—and 6 weapon confiscations.

The California Men's Colony has an operational housing capacity of 6,294, but it currently houses 6,574 inmates, with 280 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 151 incidents of assault/battery by inmates—33 of them against CDCR staff—along with 11 riots/melees, and 29 weapon confiscations

The California State Prison at Corcoran has an operational housing capacity of 4,954, but it currently houses 5,317 inmates, with 363 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 147 incidents of assault/battery by inmates—58 of them against CDCR staff—along with 5 riots/melees, and 111 weapon confiscations.

The California Rehabilitation Center has an operational housing capacity of 4,660, but it currently houses 4,856 inmates, with 196 inmates housed in areas designed for other purposes At the same time, in the last year, there were 65 incidents of assault/battery by inmates—28 of them against CDCR staff—9 riots/melees, and 34 weapon confiscations

The Correctional Training Facility has an operational housing capacity of 6,157, but it currently houses 7,027 inmates, with 870 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 85 incidents of assault/battery by inmates—26 of them against CDCR staff—along with 9 riots/melees, and 27 weapon confiscations

Chuckawalla Valley State Prison has an operational housing capacity of 3,443, but it currently houses 4,292 inmates, with 849 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 50 incidents of assault/battery by inmates—11 of them against CDCR staff—along with 5 riots/melees, and 21 weapon confiscations

Deuel Vocational Institution has an operational housing capacity of 3,115, but it currently houses 3,911 inmates, with 796 inmates housed in areas designed for other purposes At the same time, in the last year, there were 114 incidents of assault/battery by inmates—54 of them against CDCR staff—along with 7 riots/melees, and 37 weapon confiscations.

High Desert State Prison has an operational housing capacity of 4,346, but it currently houses 4,706 inmates, with 360 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 351 incidents of assault/battery by inmates—44 of them against CDCR staff—along with 6 riots/melees, and 289 weapon confiscations

Ironwood State Prison has an operational housing capacity of 4,185, but it currently houses 4,665 inmates, with 480 inmates housed in areas designed for other purposes At the same time, in the last year, there were 96 incidents of assault/battery by inmates—19 of them against CDCR staff—along with 14 riots/melees, and 52 weapon confiscations

Kern Valley State Prison has an operational housing capacity of 4,566, but it currently houses 4,686 inmates, with 120 inmates housed in areas designed for other purposes At the same time, in the last year, there were 146 incidents of assault/battery by inmates—60 of them against CDCR staff—along with 10 riots/melees, and 46 weapon confiscations

The California State Prison at Los Angeles has an operational housing capacity of 4,230, but it currently houses 4,698 inmates, with 468 inmates housed in areas designed for other purposes At the same time, in the last year, there were 211 incidents of assault/battery by inmates—123 of them against CDCR staff—along with 4 riots/melees, and 101 weapon confiscations

Mule Creek State Prison has an operational housing capacity of 3,197, but it currently houses 3,929 inmates, with 732 inmates housed in areas designed for other purposes At the same time, in the last year, there were 65 incidents of assault/battery by inmates—35 of them against CDCR staff—along with 1 riot/melee, and 28 weapon confiscations

North Kern State Prison has an operational housing capacity of 5,189, but it currently houses 5,365 inmates, with 176 inmates housed in areas designed for other purposes At the same time, in the last year, there were 135 incidents of assault/battery by inmates—43 of them against CDCR staff—along with 16 riots/melees, and 70 weapon confiscations.

Pelican Bay State Prison has an operational housing capacity of 3,444, but it currently houses 3,604 inmates, with 160 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 256 incidents of assault/battery by inmates—88 of them against CDCR staff—along with 9 riots/melees, and 106 weapon confiscations.

Pleasant Valley State Prison has an operational housing capacity of 4,368, but it currently houses 5,112 inmates, with 744 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 205 incidents of assault/battery by inmates—59 of them against CDCR staff—along with 12 riots/melees, and 26 weapon confiscations

The Richard J Donovan Correctional Facility has an operational housing capacity of 4,120, but it currently houses 4,720 inmates, with 600 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 244 incidents of assault/battery by inmates—118 of them against CDCR staff—along with 11 riots/melees, and 96 weapon confiscations

The California State Prison at Sacramento has an operational housing capacity of 2,973, but it currently houses 3,213 inmates, with 240 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 264 incidents of assault/battery by inmates—159 of them against CDCR staff—along with 5 riots/melees, and 118 weapon confiscations

The California Substance Abuse Treatment Facility and State Prison at Corcoran has an operational housing capacity of 6,360, but it currently houses 7,593 inmates, with 1,233 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 120 incidents of assault/battery by inmates—53 of them against

CDCR staff—along with 20 riots/melees, and 124 weapon confiscations.

The Sierra Conservation Center has an operational housing capacity of 5,657, but it currently houses 6,107 inmates, with 450 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 61 incidents of assault/battery by inmates—18 of them against CDCR staff—along with 19 riots/melees, and 50 weapon confiscations.

The California State Prison at Solano has an operational housing capacity of 5,070, but it currently houses 5,858 inmates, with 788 inmates housed in areas designed for other purposes At the same time, in the last year, there were 60 incidents of assault/battery by inmates—26 of them against CDCR staff—along with 4 riots/melees, and 114 weapon confiscations

San Quentin State Prison has an operational housing capacity of 4,933, but it currently houses 5,183 inmates, with 287 inmates housed in areas designed for other purposes. At the same time, in the last year, there were 262 incidents of assault/battery by inmates—123 of them against CDCR staff—along with 15 riots/melees, and 118 weapon confiscations.

Salinas Valley State Prison has an operational housing capacity of 4,200, but it currently houses 4,680 inmates, with 480 inmates housed in areas designed for other purposes At the same time, in the last year, there were 181 incidents of assault/battery by inmates—82 of them against CDCR staff—along with 7 riots/melees, and 91 weapon confiscations.

Valley State Prison for Women has an operational housing capacity of 3,902, but it currently houses 3,958 inmates, with 56 inmates housed in areas designed for other purposes At the same time, in the last year, there were 125 incidents of assault/battery by inmates—75 of them against CDCR staff — and 15 weapon confiscations.

Wasco State Prison has an operational housing capacity of 5,838, but it currently houses 6,098 inmates, with 260 inmates housed in areas designed for other purposes At the same time, in the last year, there were 226 incidents of assault/battery by inmates—97 of them against CDCR staff—along with 32 riots/melees, and 82 weapon confiscations

WHEREAS, some of these 29 severely overcrowded prisons may even be housing more inmates, because the inmate population continually fluctuates among the CDCR prisons, and

WHEREAS, in addition to the 1,671 incidents of violence perpetrated in these 29 severely overcrowded prisons by inmates against CDCR staff last year, and the 2,642 incidents of violence perpetrated in these prisons on inmates by other inmates in the last year, the suicide rate in these 29 prisons is approaching an average of one per week, and

WHEREAS, the federal court in the Coleman case found mental-health care in CDCR prisons to be below federal constitutional standards due in part to the lack of appropriate beds and space; and

WHEREAS, the use of common areas for inmate housing has severely modified or eliminated certain inmate programs in the 29 prisons with severe overcrowding; and

WHEREAS, the severe overcrowding has also substantially limited or restricted inmate movement, causing significantly reduced inmate attendance in academic, vocational, and rehabilitation programs, and

WHEREAS, overcrowded prisons in other states have experienced some of the deadliest prison riots in American history, including:

In 1971, the nation's deadliest prison riot occurred in Attica, New York, resulting in the death of 43 people On the day of this riot, the prison—which was built for 1600—housed approximately 2,300 inmates.

In 1981, a riot occurred in the New Mexico State Penitentiary. More than 30 inmates were killed, more than 100 people were injured, and 12 officers were taken hostage, some of whom were beaten, sexually assaulted, and/or raped. On the day of this riot, the prison—which was built for 900—housed approximately 1,136 inmates.

In 1993, a riot occurred in Lucasville, Ohio. One officer was murdered, four officers were seriously injured, and nine inmates were killed On the day of this riot, the prison—which was built for 1600—housed approximately 2,300 inmates

WHEREAS, I believe immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding, and

WHEREAS, because of the housing shortage in CDCR prisons, the CDCR has current contracts with four California counties to house 2,352 additional state inmates in local adult jails, but this creates the following overcrowding problem in the county jails

According to a report by the California State Sheriffs' Association in June 2006, adult jails recently averaged a daily population of approximately 80,000 inmates. On a typical day, the county jails lacked space for more than 4,900 inmates across the state.

Based on the same report, 20 of California's 58 counties have court-imposed population caps resulting from litigation brought by or on behalf of inmates in crowded jails and another 12 counties have self-imposed caps

Most of California's jail population consists of felony inmates, but when county jails are full, someone in custody must be released before a new inmate can be admitted

The 2006 Sheriffs' Association report states that last year, 233,388 individuals statewide avoided incarceration or were released early into local communities because of the lack of jail space

WHEREAS, overcrowding conditions are projected to get even worse in the coming year, to the point that the CDCR expects to run out of all common area space to house prisoners in mid-2007, and will be unable to receive any new inmates, and

WHEREAS, in January 2006, I proposed $6 billion in the Strategic Growth Plan to help manage inmate population at all levels of government by increasing the number of available local jail beds and providing for two new prisons and space for 83,000 prisoners to address California's current and future incarceration needs, and

WHEREAS, the California Legislature failed to act upon this proposal; and

WHEREAS, in March 2006, a proposal was submitted as part of my 2006-07 budget to enable the CDCR to contract for a total of 8,500 beds in community correctional facilities within the state; and

WHEREAS, the California Legislature denied this proposal, and

WHEREAS, on June 26, 2006, I issued a proclamation calling the Legislature into special session because I believed urgent action was needed to address this severe problem in California's prisons, and I wanted to give the Legislature a further opportunity to address this crisis; and

WHEREAS, the CDCR submitted detailed proposals to the Legislature to address the immediate and longer-term needs of the prison system in an effort resolve the overcrowding crisis; and

WHEREAS, the California Legislature failed to adopt the proposals submitted by the CDCR, and also failed to adopt any proposals of its own; and

WHEREAS, in response, my office directed the CDCR to conduct a survey of certain inmates in California's general population to determine how many might voluntarily transfer to out-of-state correctional facilities, and

WHEREAS, the CDCR reports that more than 19,000 inmates expressed interest in voluntarily transferring to a correctional facility outside of California, and

WHEREAS, the overcrowding crisis gets worse with each passing day, creating an emergency in the California prison system.

NOW, THEREFORE, I, ARNOLD SCHWARZENEGGER, Governor of the State of California, in light of the aforementioned, find that conditions of extreme peril to the safety of persons and property exist in the 29 CDCR prisons identified above, due to severe overcrowding, and that the magnitude of the circumstances exceeds the capabilities of the services, personnel, equipment, and facilities of any geographical area in this state. Additionally, the counties within the state are harmed by this situation, as the inability to appropriately house inmates directly impacts local jail capacity and the early release of felons. This crisis spans the eastern, western, northern, and southern parts of the state and compromises the public's safety, and I find that local authority is inadequate to cope with the emergency. Accordingly, under the authority of the California Emergency Services Act, set forth at Title 2, Division 1, Chapter 7 of the California Government Code, commencing with section 8550, I hereby proclaim that a State of Emergency exists within the State of California's prison system.

Pursuant to this proclamation:

1 The CDCR shall, consistent with state law and as deemed appropriate by the CDCR Secretary for the sole purpose of immediately mitigating the severe overcrowding in these 29 prisons and the

resulting impacts within California, immediately contract for out-of-state correctional facilities to effectuate voluntary transfers of California prison inmates to facilities outside of this state for incarceration consisting of constitutionally adequate housing, care, and programming

II. The CDCR Secretary shall, after exhausting all possibilities for voluntary transfers of inmates, and in compliance with the Interstate Corrections Compact and the Western Interstate Corrections Compact, and as he deems necessary and appropriate to mitigate this emergency, effectuate involuntary transfers of California prison inmates, based on criteria set forth below, to institutions in other states and those of the federal government for incarceration consisting of constitutionally adequate housing, care, and programming In such instance, because strict compliance with California Penal Code sections 11191 and 2911 would prevent, hinder, or delay the mitigation of the severe overcrowding in these prisons, applicable provisions of these statutes are suspended to the extent necessary to enable the CDCR to transfer adult inmates, sentenced under California law, to institutions in other states and those of the federal government without consent This suspension is limited to the scope and duration of this emergency.

A. The CDCR Secretary shall prioritize for involuntary transfer the inmates who meet the following criteria:

1. Inmates who (a) have been previously deported by the federal government and are criminal aliens subject to immediate deportation, or (b) have

committed an aggravated felony as defined by federal statute and are subject to deportation

2. Inmates who are paroling outside of California

3. Inmates who have limited or no family or supportive ties in California based on visitation records and/or other information deemed relevant and appropriate by the CDCR Secretary.

4. Inmates who have family or supportive ties in a transfer state.

5. Other inmates as deemed appropriate by the CDCR Secretary.

B. No person under commitment to the Division of Juvenile Justice may be considered for such transfer

III. The CDCR Secretary shall, before selecting any inmate for transfer who has individual medical and/or mental-health needs, consult with the court-appointed Receiver of the CDCR medical system and/or the court-assigned Special Master in the Coleman mental-health case, depending on the healthcare needs of the inmate, to determine whether a transfer would be appropriate

IV. The CDCR Secretary shall, before effectuating any inmate transfer, carefully and thoroughly evaluate all appropriate factors, including, but not limited to, the cost-effectiveness of any such transfer and whether an inmate selected for transfer has any pending appeals or hearings that may be impacted by such transfer

V. The CDCR shall, as deemed appropriate by the CDCR Secretary, contract for facility space, inmate transportation, inmate screening, the services of qualified personnel, and/or for the supplies, materials, equipment, and other services needed to immediately mitigate the severe overcrowding and the resulting impacts within California. Because strict compliance with the provisions of the Government Code and the Public Contract Code applicable to state contracts would prevent, hinder, or delay the mitigation of the severe overcrowding in these prisons, applicable provisions of these statutes, including, but not limited to, advertising and competitive bidding requirements, are suspended to the extent necessary to enable the CDCR to enter into such contracts as expeditiously as possible This suspension is limited to the scope and duration of this emergency.

I FURTHER DIRECT that as soon as hereafter possible, this proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this proclamation.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 4th day of October 2006

ARNOLD SCHWARZENEGGER

Governor of California

ATTEST:

BRUCE McPHERSON

Secretary of State

APPELLEE'S BRIEF

Supreme Court, U.S.
FILED
AUG 27 2010
THE CLERK

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from an Order of the Three-Judge Court in the United States District Courts for the Northern District of California and the Eastern District of California

INTERVENORS' OPENING BRIEF

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QUESTIONS PRESENTED

1. Whether the three-judge district court had jurisdiction to issue the "prisoner release order" pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626.

2. Whether the court below properly interpreted and applied Section 3626(a)(3)(E), which requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right; and . . . no other relief will remedy the violation of the Federal Right" in order to issue a "prisoner release order."

3. Whether the three-judge court's "prisoner release order," which was entered to address the allegedly unconstitutional delivery of medical and mental health care to two classes of California inmates, but mandates a system-wide population cap within two years that will require a population reduction of approximately 46,000 inmates, satisfies that PLRA's nexus and narrow tailoring requirements while giving sufficient weight to potential adverse effects on public safety and the State's operation of its criminal justice system.

PARTIES TO THE PROCEEDING

Intervenors: [1]

> The California State Republican Senator and Assembly Intervenors (collectively the "Legislator Intervenors") include the following current or former California State Senators: Senators Samuel Aanestad, Roy Ashburn, James F. Battin, Jr., John J. Benoit, Robert Dutton, Dennis Hollingsworth, Bob Huff, Abel Maldonado, George Runner, Tony Strickland, Mimi Walters and Mark Wyland; and the following current or former California Assemblymembers: Michael N. Villines, Anthony Adams, Joel Anderson, Bill Berryhill, Tom Berryhill, Sam Blakeslee, Connie Conway, Paul Cook, Chuck DeVore, Bill Emmerson, Jean Fuller, Ted Gaines, Martin Garrick, Danny Gilmore, Curt Hagman, Diane Harkey, Shirley Horton, Guy S. Houston, Kevin Jeffries, Rick Keene, Steven Knight, Dan Logue, Doug La Malfa, Bill Maze, Jeff Miller, Brian Nestande, Jim Nielson, Roger Niello, Sharon Runner, Jim Silva, Cameron Smyth, Todd Spitzer, Audra Strickland, and Van Tran.
>
> The District Attorney intervenors include the following: Rod Pacheco, District Attorney County of Riverside, Bonnie M. Dumanis, District Attorney County of San Diego, Tony Rackauckas, District Attorney County of Orange, Jan Scully, District Attorney County of Sacramento, Christie Stanley, District Attorney County of Santa Barbara, Michael A. Ramos, District Attorney

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[1] The parties designated under this heading shall be referred to through the remainder of this brief as the "Intervenors."

County of San Bernardino, Robert J. Kochly, District Attorney County of Contra Costa, David W. Paulson, District Attorney County of Solano, Gregg Cohen, District Attorney County of Tehama, Todd Riebe, District Attorney County of Amador, Bradford R. Fenocchio, District Attorney County of Placer, John R. Poyner, District Attorney County of Colusa, Michael Ramsey, District Attorney County of Butte, Gerald T. Shea, District Attorney County San Luis Obispo, Edward R. Jagels, District Attorney County of Kern, Gregory Totten, District Attorney County of Ventura, Vern Pierson, District Attorney County of El Dorado, Clifford Newell, District Attorney County of Nevada, Ronald L. Calhoun, District Attorney County of Kings, and Donald Segerstrom, District Attorney County of Tuolumne.

The Sheriff, Police Chief, Probation Chief and Corrections Intervenors include the following: Amador County Sheriff-Coroner Martin Ryan, Butte County Sheriff Perry Reniff, Calaveras County Sheriff Dennis Downum, El Dorado County Sheriff Jeff Neves, Fresno County Sheriff Margaret Mims, Glenn County Sheriff Larry Jones, Inyo County Sheriff William Lutze, Kern County Sheriff Donny Youngblood, Lassen County Sheriff Steve Warren, Los Angeles County Sheriff Lee Baca, Merced County Sheriff Mark Pazin, Mono County Sheriff Rick Scholl, Monterey County Sheriff Mike Kanalakis, Orange County Sheriff-Coroner Sandra Hutchens, Placer County Sheriff Edward Bonner, San Benito County Sheriff-Coroner Curtis Hill, San Diego County Sheriff William Gore, San Joaquin County Sheriff-Coroner Steve Moore, San Luis

Obispo County Sheriff Pat Hedges, Santa Barbara County Sheriff Bill Brown, Santa Clara County Sheriff Laurie Smith, Solano County Sheriff-Coroner Gary Stanton, Stanislaus County Sheriff-Coroner Adam Christianson, Sutter County Sheriff-Coroner J. Paul Parker, Tehama County Sheriff Clay Parker, Tuolumne County Sheriff-Coroner James Mele, Ventura County Sheriff Bob Brooks, Yolo County Sheriff Ed Prieto, Yuba County Sheriff Steve Durfor, City of Fremont Police Chief Craig Steckler, City of Fresno Police Chief Jerry Dyer, City of Grover Beach Police Chief Jim Copsey, City of Modesto Police Chief Michael Harden, City of Pasadena Police Chief Bernard Melekian, City of Paso Robles Police Chief Lisa Solomon, City of Roseville Police Chief Michael Blair, Contra Costa County Chief Probation Officer Lionel Chatman, Fresno County Chief Probation Officer Linda Penner, Mariposa County Chief Probation Officer Gail Neal, Sacramento County Chief Probation Officer Don Meyer, San Luis Obispo Chief Probation Officer Jim Salio, Solano County Chief Probation Officer Isabelle Voit, Stanislaus County Chief Probation Officer Jerry Powers, and Ventura County Chief Probation Officer Karen Staples.

Appellants:

Governor Arnold Schwarzenegger

Matthew Cate, Secretary of the California Department of Corrections and Rehabilitation

John Chiang, California State Controller

Ana J. Matosantos, Director of the California Department of Finance

Stephen W. Mayberg, Director of the Department of Health

Plaintiffs Below:

Gilbert Aviles
Ralph Coleman
Paul Decasas
Raymond Johns
Joseph Long
Marciano Plata
Steven Bautista
Ray Stoderd
Otis Shaw
Leslie Rhoades
Clifford Myelle

Intervenor-Plaintiff:

California Correctional Peace Officers' Association

Other Intervenor-Defendants Below:

County of San Mateo
County of Santa Barbara
County of Santa Clara
County of Solano
County of Sonoma

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IN THE

Supreme Court of the United States

No. 09-1233

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,
v.
MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from an Order of the Three-Judge Court in the United States District Courts for the Northern District of California and the Eastern District of California

INTERVENORS' OPENING BRIEF

OPINIONS BELOW

The three-judge court's August 4, 2009 Opinion and Order (*Coleman* D.E. 3641; *Plata* D.E. 2197) *See* JS1-App. 1a-256a;[1] also found at 2009 WL 2430820

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[1] Intervenors cite the State's Appendix to the Jurisdictional Statement filed in Supreme Court of the United States Case Number 09-416, as "JS1-App." and the State's Appendix to the Jurisdictional Statement in this case as "JS2-App." The records in *Coleman*, No. CIV-S-90-0520-LKK (E.D. Cal.) and *Plata*, No. C01-1351-TEH (N.D. Cal.) are cited by docket entry number (*i.e.*, "*Coleman* D.E. __", "*Plata* D.E. __") in the Rule 33.2 version of this brief, as well as in the booklet version when the cited materials are not included in the deferred joint appendix. Citations to the Deferred Joint Appendix are listed as "DJA."

(E.D. Cal/N.D. Cal. Aug. 4, 2009). The three-judge court's January 12, 2010 Order to Reduce Prison Population (*Coleman* D.E. 3767; *Plata* D.E. 2287). *See* JS2-App. 1a-10a; *also found at* 2010 WL 99000 (E.D. Cal/N.D. Cal. Jan. 12, 2010).

JURISDICTION

The three-judge court entered its Opinion and Order on August 4, 2009. JS1-App. 1a-256a. That order granted injunctive relief pursuant to the Prison Litigation Reform Act, 18 U.S.C. § 3626. In its August 4, 2009 Opinion and Order, the three-judge court ordered Governor Schwarzenegger and the other defendants (collectively referred to as the "State") to draft a prison population reduction plan. The State submitted a proposed population reduction plan on September 18, 2009, which would have reduced the prison population below 137.5% of design capacity within five years, as opposed to the two-year reduction dictated in the August 4, 2009 order. The three-judge court rejected the plan and the State submitted a revised plan on November 12, 2009. On January 12, 2010, the three-judge court issued an order adopting the revised plan. The State filed its notice of appeal on January 20, 2010. *See* JS2-App 17a. The jurisdiction of this Court rests on 28 U.S.C. § 1253, providing for a direct appeal from decisions of three-judge courts.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

This appeal concerns the interpretation and application of the Prison Litigation Reform Act, 18 U.S.C. § 3626.

STATEMENT OF THE CASE

The plaintiffs in the class action lawsuits *Plata v. Schwarzenegger*, District Court for the Northern District of California, Case No. C 01-1351 TEH, involving claims of constitutionally inadequate provision of medical care in state prisons, and *Coleman v. Schwarzenegger*, District Court for the Eastern District of California, Case No. S-90-0520-LKK-JFM P, involving claims of constitutionally inadequate provision of mental health care in state prisons, moved to convene a three-judge court to consider the issuance of a prisoner release order pursuant to the Prison Litigation Reform Act, 18 U.S.C. § 3626 ("PLRA"). Both courts had previously determined that the California Department of Corrections and Rehabilitation ("CDCR") failed to provide prison inmates with constitutionally adequate medical and mental health care. To remedy these constitutional violations, the *Coleman* court appointed a special master ("Special Master") to oversee development and implementation of a plan to remedy the unconstitutional provision of mental health care, JS1-App. 36a. In early 2006, the *Plata* court appointed a receiver ("Receiver") to take control of all aspects of the CDCR relating to the provision of medical care, and to bring the CDCR into constitutional compliance. JS1-App. 29a-30a. District Court Judges Henderson and Karlton granted the respective plaintiffs' motions to convene a three-judge court on July 23, 2007. *See* JS1-App. 62a-69a. The Chief Judge of the Ninth Circuit Court of Appeals at the time, Mary Schroeder, consolidated the two cases and appointed Judge Henderson, Judge Karlton and Ninth Circuit Court of Appeals Judge Stephen Reinhardt to the three-judge court. Shortly after the establishment of the three-judge court, Appellants were permitted to intervene as of right in the proceedings. *See* JS1-App. 69a.

To issue a prisoner release order, the PLRA mandates that the three-judge court must find "by clear and convincing evidence that – (i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E).

The PLRA further mandates that prospective relief may be afforded only when it is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A) In fashioning the relief, the three-judge court must "give substantial weight to any adverse impact on public safety or the operation of a criminal justice system cause by the relief" *Id.*

Trial commenced on November 18, 2008, with final oral argument concluding on February 3 and 4, 2009. The three-judge court determined, in an opinion and order dated August 4, 2009, that overcrowding was the primary cause of the constitutionally inadequate provision of medical and mental health care and that no other relief could remedy the violations. *See* JS1-App. 78a-168a. In its opinion and order, the three-judge court ordered the State to create and file "a population reduction plan that will in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity." JS1-App. 255a. On September 18, 2009, the State submitted a population plan that provided for a population reduction below 137.5% in five years, based on the defendants' concerns that "reducing the prison population to 137.5% within a two-year period cannot be accomplished without unacceptably compromising public safety." JS1-App. 317a & n.1. On October 21, 2009, the three-judge court rejected this population reduction plan and ordered the State to prepare a revised plan which would accomplish the ordered population reduction within two years. DJA Vol. IV 1525-1532. The State submitted a revised plan on November 12, 2009 (JS2-App. 25a-70a), which the three-judge court subsequently adopted in its January 12, 2010 Order to Reduce Prison Population. *See* JS2-App. 1a-10a. Together with its August 4, 2009 order, this January 12, 2010 Order to Reduce Prison Population is a "Prisoner Release Order" under the terms of the PLRA. *See* JS2-App 1a-10a.

The State appealed the August 4, 2009, and January 12, 2010 orders (collectively the "Prisoner Release Orders") and submitted its Jurisdictional Statement on April 12, 2010. The Intervenors filed a separate appeal and Jurisdictional Statement, docketed as Case Number 09-1232. On June 14, 2010, this Court accepted review of the State's appeal. Intervenors are parties to the judgment below and, accordingly, submit this brief addressing the second and third Questions Presented by the State

SUMMARY OF ARGUMENT

This appeal challenges the only Prisoner Release Orders ever issued over a defendant's objection since the enactment of the PLRA. The Prisoner Release Orders below mandate that the California prison population be reduced by the release or non-incarceration of tens of thousands of duly arrested convicted and sentenced criminals and pose a grave threat to public safety in California. As discussed in detail in the Brief of Appellants, the three-judge court was improperly convened and, accordingly, lacked jurisdiction to make the Prisoner Release Orders. Even had the district court been properly convened, the judgment below would be subject to reversal for failure to comply with PLRA. Specifically, the court below found – purportedly by clear and convincing evidence – overcrowding to be the statutory "primary cause" of Eighth Amendment violations relating to medical and mental health care but refused to hear evidence and argument that no such violations were current and ongoing at the time of trial. The three-judge court also held that no alternatives to the Prisoner Release Orders existed notwithstanding evidence from the *Plata* Receiver and Appellees' own expert that alternatives to the Prisoner Release Orders did exist. The Receiver stated, approximately a month before trial began, "I'm just not seeing difficulty in providing medical services no matter what the population is." DJA Vol. IV 1222-1236 (Trial Declaration of Assemblymember Todd Spitzer, ¶ 28 and Exhibit D thereto, at 30:00 minutes). The Prisoner Release Orders issued by the court below further violated the PRLA because they were not narrowly tailored to the medical and mental health care issues in the underlying class actions. Specifically, the district court acknowledged that the Prisoner Release Orders were, "likely to affect inmates without medical conditions or serious mental illness." JS1-App. 172a. That is an understatement. The Prisoner Release Orders will free tens of thousands of criminals and, at the same time, offer no assurance of correcting any continuing Eighth Amendment violations. The district court stated, "We recognize that other factors contribute to California's failure to provide its inmates with constitutionally adequate medical and mental health care, and that reducing crowding in the prisons will not, without more, completely cure the constitutional violations that the *Plata* and *Coleman* court have sought to remedy" JS1-App. 143a. Finally, the PLRA requires the three-judge court to give "substantial weight" to public safety in determining whether to issue Prisoner Release Orders and how any such Orders are to be implemented. The court below failed to give substantial weight to public safety and, indeed, admitted that it did not even "evaluate[] the public safety impact of each element of the State's proposed plan." JS2-App. 3a. Instead, the court below purported to "trust that the State will comply with its duty to ensure public safety as it implements the constitutionally required reduction." JS2-App. 4a. However, the trust expressed by the district court is misplaced because it rejected a five year population reduction plan proposed by the State and instead ordered the same reduction over a compressed two-year period notwithstanding the express warning of the State that the Prisoner Release Order could not be implemented "without unacceptably compromising public safety." JS1-App. 317a & n.1. This is particularly true because the Prisoner Release Orders fail to ensure funding for and implementation of programs necessary to mitigate the potentially devastating effect on public safety of simply releasing tens of thousands of criminals into California's communities. For all these reasons, the judgment below should be reversed.

ARGUMENT

To protect the ability of States to operate and maintain their own criminal justice systems and to protect public safety, the PLRA permits federal courts to issue prisoner release orders only under limited and extraordinary circumstances. Appellees failed to establish the necessary prerequisites justifying issuance of a prisoner release order, and the Prisoner Release Orders issued by the court below exceed the scope allowed by the PLRA.[2]

This Court recognized prior to the enactment of the PLRA that federal courts are ill-equipped to entangle themselves in the operation of state prison systems and that management of state prisons is "peculiarly within the province of the legislative and executive branches of government . . . ." *Procunier v. Martinez*, 416 U.S. 396, 405 (1974), *overruled on other grounds by Thornburgh v. Abbott*, 490 U.S. 401 (1989). For this reason, "courts are ill equipped to deal with the increasingly urgent problems of the prison administration and reform." *Id., see also Lewis v. Casey*, 518 U.S. 343, 364 (1996) (Thomas, J., concurring) ("too frequently, federal district courts in the name of the Constitution effect wholesale takeovers of state correctional facilities and run them by judicial decree.")

Congress agreed and enacted the PLRA to further restrain judicial interference with the management of state prisons. "When Congress enacted the PLRA, it sought to oust the federal judiciary from day-to-day prison management." *Taylor v. United States*, 181 F.3d 1017, 1027 (9th Cir. 1999) (*en banc*) (Wardlaw, J., dissenting); *see also Woodford v. Ngo*, 548 U.S. 81, 93 (2006) ("The PLRA attempts to eliminate unwarranted federal-court interference with the administration of prisons. . . ."); *Miller v. French*, 530 U.S. 327, 347 (2000) ("The PLRA has restricted courts' authority to issue and enforce prospective relief concerning prison conditions. . . ."). Congress was particularly skeptical and demanded higher scrutiny of population caps and prisoner release orders such as those ordered by the three-judge court below. *See Castillo v. Cameron County, Tex.*, 238 F.3d 339, 348 (5th Cir. 2001) (noting that the legislative history of the PLRA reveals Congress' apprehension regarding population caps); *Gilmore v. California*, 220 F.3d 987, 998 & n.14 (9th Cir. 2000) (same); 141 Cong. Rec. S14408-01, S14414 (daily ed. Sept. 27, 1995) (statement of Sen. Dole) ("Perhaps the most pernicious form of judicial micromanagement is the so-called prison population cap"); 141 Cong. Rec. S2648-02, S2649 (daily ed. Feb 14, 1995) (statement of Sen. Hutchinson) ("This bill will curb the ability of Federal Courts to take over the policy decisions of State prisons. . . .").

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[2] Intervenors do not address the first Question Presented· "Whether the three judge district court had jurisdiction to issue a "prisoner release order" pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U S C § 3626." Intervenors join in the arguments made by the State with respect to that Question

The Prison Release Orders in this case typify the federal interference with a State's ability to manage its prisons that the PLRA sought to eliminate. The Intervenors – police chiefs, sheriffs, probation officers, district attorneys and legislators from across California – joined this litigation for the express purpose of opposing the issuance of a prisoner release order and vindicating the public safety interests of the millions of California citizens placed at risk by such an order. On behalf of those citizens, and the millions more Americans that could be affected by similar orders in the future, the Intervenors respectfully request that this Court reverse the judgment below.

1. THE PRISONER RELEASE ORDERS SHOULD NOT HAVE BEEN ENTERED BECAUSE THERE WAS NO SHOWING THAT PAST EIGHTH AMENDMENT VIOLATIONS WERE CURRENT AND ONGOING AND BECAUSE ALTERNATIVE REMEDIES EXISTED

Under the PLRA, a three-judge court "shall enter a prisoner release order only if the court finds by clear and convincing evidence that – (i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E). The Prisoner Release Orders issued below fail to satisfy either requirement.

Congress drafted the PLRA in the present tense, permitting issuance of prospective prisoner release orders only to correct current and ongoing violations of Federal rights, not to provide a remedy to plaintiffs to compensate them for past wrongs or to address overcrowding in prisons simply to alleviate overcrowding. Notwithstanding this mandate, the three-judge court prohibited the introduction of evidence and argument on the issue of whether past violations were "current and ongoing" at the time of the trial. JS1-App. 78a n.42; *see also* JS1-App. 77a

The Intervenors specifically requested from the three-judge court a determination of what constitutional violations, if any, remained at the time of trial and offered to present evidence and argument that there were no such ongoing violations. The request and the offer of the Intervenors were refused by the three-judge court. DJA Vol. VI 2081-2087 (Trial Tr. at 57:11-58:13). "Sir, I am the very source of patience. If you believe that, I'll sell you a piece of the Brooklyn

Bridge really cheap. Twice this court has said we will not receive that evidence [of the absence of current constitutional violations]. You have made as clear a record as you can.").

Instead of determining whether any current violations existed, the three-judge court's analysis focused only on "whether . . . requiring a reduction in the population of California's prisons was necessary to remedy the previously identified constitutional violations[.]" JS1-App.77a. As a result, by the time that the three-judge court made its initial August 4, 2009 order, no determination had been made regarding alleged violations since July 2007. *Id.* Indeed, neither the *Coleman* nor the *Plata* single-judge courts had held evidentiary hearings regarding the state of the prisons and ongoing violations since September 13, 1995 (*Coleman*) and June 9, 2005 (*Plata*). *See* JS1-App. 23a, 33a. Had the three-judge court permitted such evidence and argument at trial, the Intervenors, as well as the State, would have provided compelling evidence regarding massive increases in prison spending and the allocation of resources resulting in substantial overall improvements in medical and mental health care. *See, e.g.*, DJA Vol. V 1690-1691 (Pre-Trial Hr'g Tr. at 28:16-29:2 (E.D. Cal./N.D. Cal. Nov. 10, 2008)); DJA Vol. 6 2081-2087 (Trial Tr. at 6:24-7:9, 57:11-58:13 (E.D. Cal./N.D. Cal. Nov. 18, 2008)).

For example, while a stated basis for the underlying Prisoner Release Orders was the rate of inmate mortality in California prisons, federal studies demonstrate that state prison inmates enjoy a lower mortality rate than the comparable age cohort of the public at large[3] and that California inmates have consistently had lower mortality rates than inmates in almost all other state prison systems.[4] Ironically, the Pennsylvania state prison system, which produced two of the expert witnesses upon whom the three-judge court relied, possessed the third highest inmate mortality rate among all 50 States during the same time.[5] In sum, the plain language of the PLRA – written as it is in the present tense – requires Appellees to demonstrate that overcrowding "is" the primary cause of current and ongoing constitutional violations. The three-judge court not only refused to require Appellees to do so, it impermissibly precluded Intervenors from offering evidence and argument to demonstrate the complete lack or, at most, limited nature of any such violations.

A prisoner release order may issue only if a plaintiff demonstrates – by clear and convincing evidence –

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[3] United States Department of Justice, Bureau of Justice Statistics, Christopher J. Mumola, *Brief Medical Causes of Death in State Prisons 2001-2004*, (January 2007) ("*Medical Causes of Death in State Prisons 2001-2004*"), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mcdsp04.pdf. This report reflects an average citizen mortality rate of 308 per 100,000 and an inmate mortality rate of 250 per 100,000 per year. This phenomenon is summarized in a U.S. Department of Justice press release entitled "Death Rates Lower in State Prisons Than in the General Population," United States Department of Justice, Office of Justice Programs, January 21, 2007, *available at* http://www.ojp.usdoj.gov/newsroom/pressreleases/2007/BJS07010.htm.

[4] U.S. Department of Justice, Bureau of Justice Statistics, *State Prison Deaths 2001-2006*, (Table 8) (2008) [finding that the composite mortality rate for California prison inmates was lower than inmate mortality in 37 other states], *available at* http://bjs.ojp.usdoj.gov/content/dcrp/prisonindex.cfm.

[5] *Id.*

that "no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E). Appellees failed to meet this burden and the evidence before the threejudge court actually established that a prisoner release order was not necessary to address any constitutional violations that might have existed at the time of trial. Most significantly, the Receiver and Appellees' expert, both provided evidence demonstrating that a prisoner release order was not necessary to achieve and maintain constitutional levels of care. The *Plata* Receiver stated that, under his control, the California prison systems would not have any "difficulty in providing medical services [to the entire prison population] no matter what the population is." DJA Vol. IV 1222-1236 (Trial Declaration of Assemblymember Todd Spitzer, ¶ 28 and Exhibit D thereto, at 30:00 minutes and 31:20 minutes (E.D. Cal./N.D. Cal. Oct. 30, 2008)).[6] Similarly, Appellees' expert, Dr. Ronald Shansky, testified that California could provide constitutionally adequate care for more than 172,000 inmates if other reforms were implemented. Shansky Dep. at 144:3-14 (Dec. 10, 2007); *see also* DJA Vol. VI 2280-2281 (Trial Tr. at 491:19-492:08 (E.D. Cal./N.D. Cal. Nov. 21, 2008) (Dr. Shansky admits that additional changes beyond those set forth in the Receiver's "Turnaround Plan" (*Plata* D.E. 1229) were not needed to bring the CDCR's provision of medical care into compliance, and that the "Turnaround Plan" did not envision a population reduction)). Nothing in the three-judge court's

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[6] The parties were limited to such "out-of-court" evidence from the Receiver because the three-judge court refused to permit discovery on the Receiver and refused to have him testify in court. *See* Protective Order re Deposition of Receiver (E.D. Cal./N.D. Cal. Nov. 29, 2007) (*Coleman* D.E. 2577, *Plata* D.E. 988).

Prisoner Release Orders reconciles the uncontroverted evidence adduced from the Receiver and Appellees' expert above that a release order was not necessary and that other alternatives to a prisoner release order existed.[7] The Prisoner Release Orders issued here were clearly not "the remedy of last resort" as envisioned by Congress. H.R.Rep. No. 104-21, at 25 (1995).

The three-judge court erred by issuing the Prisoner Release Orders notwithstanding viable alternatives currently underway, including the continued work of the court-appointed Receiver and Special Master. Moreover, the three-judge court improperly rejected a number of viable alternatives to a prisoner release order on the belief that such alternatives were too speculative or would take too long to implement. JS1-App. 145a-162a. One such alternative was the possibility of transferring California inmates to out-of-state facilities. JS1-App. 159a-161a. The three-judge court rejected the alternative because "we conclude that the transfer of inmates to out-of-state facilities would not on its own begin to provide an adequate remedy for the constitutional deficiencies in the medical and mental health care provided to California inmates." JS1-App. 161a. This criticism, however, applies with equal force to the Prison Release Orders. JS1-App. 134a ("We find that reducing crowding is a necessary but not sufficient condition for eliminating the constitutional deficiencies in the provision of medical care to California's inmate population."), 143a ("We recognize that other factors contribute to California's failure to provide its inmates with constitutionally adequate medical and mental health care, and that reducing crowding in the prisons will not, without more, completely cure the Constitutional violations the *Plata* and *Coleman* courts have sought to remedy."). Finally, even if it had been shown that none of the alternatives to a prisoner release order discussed at trial – such as out-of-state transfers, remand to federal custody of undocumented prisoners, additional construction of facilities, additional hiring and continuance of the work of the Receiver and Special Master – alone could remedy any current constitutional violations, the three-judge court erred by not determining that a combination of the alternatives set forth above could be used together as an alternative to the Prisoner Release Orders.

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[7] Indeed, on May 17, 2010, the Receiver sent correspondence to Intervenor Assembly Member Martin Garrick urging support, not for a prisoner release order, but for passage of the final legislation necessary for construction of additional facilities targeted directly at further improving medical and mental health care in the California prisons He stated, "[a]pproval of AB 552 in order to fund our negotiated construction plan will represent a significant step towards conclusion of the Federal Receivership." Letter from the Hon J Clark Kelso to the Hon. Martin Garrick, dated May 17, 2010 Assembly Bill 552 was approved by the California State Senate in a bi-partisan 30-0 vote, including each of the Intervenors that cast a vote AB 552 was enacted on June 3, 2010

2. THE PRISONER RELEASE ORDERS ARE NOT NARROWLY DRAWN, ARE NOT THE LEAST INTRUSIVE MEANS TO REMEDY ANY REMAINING VIOLATIONS AND FAIL TO GIVE SUBSTANTIAL WEIGHT TO PUBLIC SAFETY

a. The Prisoner Release Orders Fail To Satisfy The PLRA's Requirement That Any Such Relief Be Both Narrowly Drawn And The Least Intrusive Means To Remedy Violation Of The Federal Right.

The PLRA provides that a prisoner release order is valid only if the order "is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). The Prisoner Release Orders here fail in at least four respects.

The three-judge court refused to consider whether previously identified constitutional violations existed at the time of trial and, if so, the scope of any such continuing violations. DJA Vol. VI 2081-2087 (Trial Tr. at 57:11-58.13 (E.D. Cal./N.D. Cal. Nov. 18, 2008)). Nor did the three-judge court endeavor to determine which, if any, of the thirty-three facilities within the California prison system failed to provide constitutional levels of care at the time of trial. *Id.* The result is an overbroad and overreaching systemwide release order that fails to identify adequately or correct any present violation of the Federal rights of a particular plaintiff or plaintiffs. *See Hines v. Anderson*, 547 F.3d 915, 922 (8th Cir. 2008) (affirming dismissal of an order under the PLRA that was not tailored to the specific violation at issue because it addressed medical conditions generally rather than "a particular medical issue that existed at the time.").

Though it had been several years since any determination that conditions in the California prison system violated any Federal right and many years since any evidentiary hearing on the existence of constitutional violations, the trial court refused to hear evidence or argument at trial that no Eighth Amendment violations were ongoing. As a result, the current record is devoid of any finding by the trial court regarding the scope or existence of an ongoing constitutional violation. In the absence of these findings, the Prisoner Release Orders cannot and do not comport with the PLRA's narrow tailoring requirement.

In any event, the Prisoner Release Orders are overbroad because they require a systemwide reduction in California's inmate population and are not targeted at correcting the alleged violations of the federal rights of members of the *Coleman* and *Plata* plaintiff classes. The wholesale reduction of the overall prison population ordered in this case provides no guarantee of remedying, in whole or part, the medical and mental health treatment issues – staffing ratios, equipment and facilities, and record-keeping – alleged by the plaintiff classes. *See* DJA Vol. IV 1222-1236 (Spitzer Trial Decl., ¶ 28 and Ex. D, at 30:00 minutes (E.D. Cal./N.D. Cal. Oct. 30, 2008) (constitutionally compliant care can be provided "no matter what the population is"); *see also id.* at 31:20 minutes ("We believe we can provide constitutional levels of care no matter what the population is.")). The PLRA, as well as respect for the federalism concerns implicated by this case, demands a more focused remedy.

Indeed, the three-judge court acknowledged that the Prisoner Release Orders are "likely to affect inmates without medical conditions or serious mental illness." JS1-App. 172a. Citing with approval Appellees' expert Dr. Pablo Stewart, the three-judge court acknowledged that a reduction of the prison population by 50,000 inmates would only affect 10,000 *Coleman* class members. JS1-App. 238a-239a. Thus, forty thousand inmates, or eighty-percent of those to be released, would not have even alleged a constitutional violation. "'[F]ederal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate the Constitution or does not flow from such a violation.'" *Missouri v. Jenkins*, 515 U.S. 70, 98 (1995) (citation omitted). The overwhelming majority of those benefitting from the Prisoner Release Orders are not affected by the purported constitutional violations, and issuing a prisoner release order simply to alleviate prison overcrowding is impermissible under the PLRA. For these reasons, the Prisoner Release Orders violate the requirement of 18 U.S.C. § 3626(a)(1)(A) that any such relief "extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." *See Hines v. Anderson*, 547 F.3d 915, 922 (8th Cir. 2008) (affirming dismissal of an order under the PLRA that was not tailored to the specific violation at 15 issue because it addressed medical conditions generally rather than "a particular medical issue that existed at the time.").

In addition to being overbroad in terms of the individuals affected, the Prisoner Release Orders are similarly overbroad in relation to the issues addressed. Under the PLRA and in the circumstances of this case, the remedy must be narrowly-tailored to redress medical and mental health issues.

A wholesale reduction of the prison population is not such a remedy. Indeed, the three-judge court acknowledged this shortcoming of its ruling. *See* JS1-App. 143a ("We recognize that other factors contribute to California's failure to provide its inmates with constitutionally adequate medical and mental health care, and that reducing crowding in the prisons will not, without more, completely cure the constitutional violations the *Plata* and *Coleman* courts have sought to remedy."); JS1-App. 157a-158a (noting the Special Master's finding that "even the release of 100,000 inmates would likely leave the defendants with a largely unmitigated need to provide intensive mental health services to program populations that would remain undiminished"); Receiver's Report re: Overcrowding at 42:24-43:1, *Plata* D.E. 673), *available at* http:///www.cprinc.org/docs/court/ReceiverReportReOvercrowding451507.pdf ("those who believe that the challenges faced by the Plan of Action are uncomplicated and who think that population controls will solve California's prison health care problems, are simply wrong."). Ironically, the Prisoner Release Orders will also likely compromise the health and increase the mortality rate of the released inmates themselves as federal studies demonstrate that state prison inmates enjoy a lower mortality rate than the comparable age cohort of the public at large.[8]

The Prisoner Release Orders issued by the three-judge court set a population cap of 137.5% of the correctional system's "design capacity" to be achieved within two years, without providing a justifiable basis for the percentage chosen. The three-judge court implied in its Prisoner Release Orders that constitutional violations had occurred because California prisons had operated for a time at levels up to 190% of design capacity (an average of nearly two inmates per cell). *See* JS1-App. 78a. However, not only is the double-celling of prisoners constitutionally permissible, California actually operates its prisons at a lower percentage of its highest-rated capacity than many other states. *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981) (Holding double-celling of inmates not violative of the Eighth Amendment and noting that "restrictive and even harsh" conditions are simply "part of the penalty criminal offenders pay for their offenses against society."). Specifically, the U.S. Department of Justice reported that, in 2008, California's prison system was operating at 106% of its highest rated capacity – substantially lower than the rate for the highest state, Massachusetts, which was operating at 140% of its highest rated capacity.[9] The federal report "Prisoners in 2008" also reported that 13 states were operating at more than 107% of its highest rated capacity and that the federal prison system was at 135% of highest rated capacity[10] The 106% of highest rated capacity assessment is consistent with the California Department of Corrections and Rehabilitation's own evaluation that they have approximately 8,000 undesirable beds in converted gymnasiums and other less than optimal locations.[11]

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[8] *See supra* footnote 3

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[9] Ranked by the Congressional Quarterly, CRIME STATE RANKINGS 2010, CONGRESSIONAL QUARTERLY (2010) Their source data is U.S Department of Justice, Bureau of Justice Statistics, *Prisoners in 2008* (December 2000), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf

[10] *See id*

[11] These are defined in California law as "temporary beds" which are defined in statute as "those that are placed in

Taken together, these facts indicate that the Prisoner Release Orders go far beyond what is necessary or permissible under the PLRA.

b. The Prisoner Release Orders Violate The PLRA Because They Fail To Give Substantial Weight To Any Adverse Impact On Public Safety And Because They Affirmatively Threaten Public Safety.

The PLRA requires any three-judge court contemplating a prisoner release order to give "substantial weight" to any adverse impact on public safety or the operation of a criminal justice system. 18 U.S.C. § 3626(a)(1)(A). Likewise, the PLRA mandates that no prisoner release order should ever issue without appropriate protection of the public. *See* 18 U.S.C. § 3626(a)(1)(A); *see also* H.R. Rep. No. 104-21, at 9 (1995); 141 Cong. Rec at S14418 (statement of Sen. Hatch). Just as the three-judge court failed to narrowly tailor the Prisoner Release Orders to remedy any current or ongoing Eighth Amendment violations, it also failed to consider meaningfully the adverse impacts on public safety that the orders would necessarily cause, abdicating its statutory responsibility and delegating it to the State. 18

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gymnasiums, classrooms, hallways, or other public spaces that were not constructed for the purpose of housing inmates" California Government Code § 15819.40(a)(3) California Assembly Bill No. 900 (Solorio/Aghazarian) (Chapter 7, Statutes of 2007) (enacted May 3, 2007), *available at* http://info.sen.ca.gov/pub/07-08/bill/asm/ab_0851-0900/ab_900_bill_20070427_enrolled.pdf, was designed, in large part, to eliminate the use of "temporary beds," though not to embrace a goal of anything approaching 100% of "design capacity" as California defines that term

U.S.C. § 3626(a)(1)(A); JS1-App. 75a-76a, 185a; JS2-App. 3a. If the requirement to consider public safety means anything, it must require, at a minimum, the three-judge court to evaluate carefully the impact each element a proposed release order would likely have on public safety. In this case, the three-judge court admits, "we have not evaluated the public safety impact of each element of the State's proposed plan." JS2-App. 3a. The three-judge court also emphasized that, "we are not endorsing or ordering the implementation of any of the specific measures contained in the State's plan, only that the State reduce the prison population to the extent and at the times designated in this Order." *Id.* The three-judge court's admitted failure to evaluate the public safety ramifications of the specific methods by which California's prison population would be reduced necessarily violates the PLRA's requirement that "substantial weight" be given to adverse impacts on public safety. This is particularly true because the court below ignored the plain warning of the State that the prison population cap ordered by the court could not be implemented in time frame ordered by the court "without unacceptably compromising public safety." JS1-App. 317a & n.1.

The three-judge court's failure to give substantial weight to adverse impacts on public safety and operation of the criminal justice system is compounded by its failure to ensure that programs and funding are available to implement the Prisoner Release Orders in a manner consistent with public safety. Without record support, the three-judge court asserted "that means exist by which the defendants can accomplish the necessary [release of approximately 46,000 prisoners[12]] without creating an adverse impact on public safety or the operation of the criminal justice system." JS2-App. 2a The court below acknowledges, however, that limiting such negative impacts depends on appropriate programs being "properly implemented." JS1-App. 195a, *see also* JS1-APP. 211a, 215a-216a, JS2-App. 3a-5a. Inexplicably, however, the three-judge court fails to order any of the protections that it identifies as necessary to ensure public safety. *See* JS1-App. 210a ("the CDCR could use risk assessment . . ."; "The State might also consider implementing . . . ."), 224a ("if a risk assessment instrument were used . . . ."), 232a-233a (leaving it to the State to decide whether to divert resources to fund community rehabilitative programs), 235a (same), 253a ("a failure by the state to comply with the experts' recommendations to take these steps would . . . be contrary to the interests of public safety"). The three-judge court abdicated its responsibility for ensuring a population reduction that complies with the PLRA by delegating full responsibility for the consideration of adverse impacts to public safety to the State defendants. JS2-App. 4a ("it is appropriate for the State to exercise its discretion in choosing which specific population reduction measures to implement, and, in doing so, to bear in mind the necessity for ensuring the public safety."), *id*. (we "trust that the State will comply with its duty to ensure public safety as it implements the constitutionally required reduction."). Indeed, the court states "[s]hould the State determine that any of the specific measures that it has included in its plan cannot be implemented without significantly affecting the public safety or the criminal justice system, we trust that it will substitute a different means of accomplishing the constitutionally required population reductions." JS2-App. 4a.[13] Boiled to their essence, the Prison Release Orders require the State to reduce the population to 137.5% of design capacity regardless of how that reduction is achieved, and impermissibly foists upon the State the court's statutory responsibility for ensuring that the Prisoner Release Orders can be implemented in a manner consistent with public safety. This approach is particularly problematic since there was no showing that the State possesses the proper analytic tools to determine with precision – to the extent that is even possible – which inmates can be released safely into the community in sufficient number to meet the three-judge court's mandatory two-year time frame.[14] *See Samson v. Califor-*

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[12] Given ordinary inmate population fluctuations, it is estimated that the Prisoner Release Orders will require the release of 38,000 to 46,000 inmates For simplicity, the Intervenors will approximate the release at 46,000 inmates.

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[13] The district court's confidence, however, is clearly misplaced because it was informed prior to issuance of the second Prisoner Release Order that, "The State . . . believe[s] that reducing the prison population to 137.5% within a two-year period cannot be accomplished without unacceptably compromising public safety." JS1-App. 317a & n.1.

[14] For example, a recent notorious sex offender, John Gardner, who drew national headlines and pled guilty to the murder of 17 year-old Chelsea King and 14 year-old Amber Dubois was originally rated low-risk by the state's static risk assessment of sex offenders. *See, e.g.*, Union Tribune Editorial Board, *Much work to be done, Chelsea's Law only the start to protect against sexual predators*, San Diego Union Tribune, June 5, 2010, *available at* http://www.signonsandiego.com/news/2010/jun/05/much-work-to-be-done/ (last visited August 26, 2010). A parolee deemed low risk enough to be placed on unsupervised parole, Javier Rueda, despite his known gang affiliation and firearms-

nia, 547 U.S. 843, 850 n.2 (2006) (recognizing that California's parolees present special dangers to the public, recognizing that they "are more akin to prisoners than probationers"); *id.* at 853-54 (crediting statistics that 68 percent of adult parolees are returned to prison, 13 percent for the commission of new felonies, and thus "grave safety concerns . . . attend recidivism").

Moreover, the court below never addresses meaningfully the issue of funding for the programs that it believes are necessary to mitigate the risks to the public posed by the contemplated prisoner release, other than to acknowledge that counties "may well require additional resources from the State in order to ensure that no significant adverse public safety impact results from the State's population reduction measures," JS2-App 5a. While the three-judge court ordered the State to "calculate the amount of additional funds that the counties may require from the State in order to maintain the level of public safety at or about the existing level," (JS2-App. 8a), the Prisoner Release Orders do nothing to ensure that such funds can or will be made available.

In the end, the three-judge court appears unconcerned about implementation of the Prisoner Release Orders and funding for programs to mitigate threats to public safety because it does not believe the massive prisoner release that it has ordered will

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related convictions was recently killed in a shootout with Los Angeles police after shooting an officer. *See* Andrew Blankstein, *Parolee suspect in shooting of LAPD officer not monitored despite alleged gang membership*, Los Angeles Times, July 15, 2010, *available at* http://latimesblogs.latimes.com/lanow/2010/07/street-gang-affiliation-not-criteria-in-decision-to-.html (last visited August 26, 2010).

increase crime in California. According to the court, "empirical evidence from California's communities demonstrates that early release programs as well as diversion . . . do not increase crime." JS1-App. 202a. The three-judge court reasoned, "[s]hortening the length of stay in prison thus affects only the timing and circumstances of the crime, if any, committed by a released inmate – *i.e.*, whether it happens a few months earlier or a few months later." JS1-App. 201a. The court below made these conclusion despite the fact that most offenders, except perhaps child molesters,[15] tend to become less criminally active and less violent as they age. *See* Freda Adler, *et al.*, CRIMINOLOGY, (1991) at 42. Prisoners receiving early release under the Prison Release Orders will be released at a younger age than if they had completed their sentences and, accordingly, can be expected to commit more crimes and cause more of an adverse effect on public safety than had they completed their terms. Moreover, these conclusions of the three-judge court regarding the possibility of a 46,000 inmate release without any adverse impact on public safety is impossible to reconcile with the undisputed trial testimony that California has an approximately 70% recidivism rate (*see* JS1-App. 189a) and that research shows that each inmate commits approximately 12 crimes before being apprehended, tried, convicted and sentenced to state prison. *See* DJA Vol. VI 2526-2529 (Trial Tr. (Police Chief Jerry Dyer) 2315:04-2318:20 (E.D. Cal./N.D. Cal. Dec. 12, 2008)). The court's reasoning fails to take into account that inmates released early will have more time in the community to commit additional crimes and also fails to recognize the basic fact that crimes that would not have occurred because of the continued incapacitation of prisoners during their incarceration, will occur if the Prisoner Release Orders are implemented and inmates gain early release. The three-judge court's conclusions also fail to account for the fact that early release emboldens offenders and accelerates the occurrence and, in some cases, the gravity, of re-offense. *See, e.g., Jack Leonard, et al., Releasing Inmates Early has a costly Human Toll*, Los Angeles Times, May 14, 2006, *available at* http://articles.latimes.com/2006/may/14/local/me-jail14; Brad Branan, *Early releases blamed in Fresno Crimes, Offenders taking advantage of jail's revolving door*, Modesto Bee, May 24, 2010, *available at* http://www.modbee.com/2010/05/24/1179391/early-releasesblamed-in-fresno.html All of these factors taken together indicate that early release under the Prisoner Release Orders will substantially increase crime in California. In contrast, scholarly studies consistently show that incarcerating felons reduces crime. One study found that incarcerating one additional prisoner reduces the number of crimes by approximately 15 per year. *See* S. D. Levitt, *The Effect of Prison Population Size on Crime Rates: Evidence from Prison Overcrowding Litigation*, Quarterly Journal of Economics 3 (1996), 319-351. Another study found that between sixteen and twenty-five FBI Index crimes are averted per year per each additional prisoner. *See* T.B. Marvell and

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[15] "It has long been observed that those who victimize adult women (rapists) tend to be younger than those who target children (child molesters)." R. Karl Hanson, Department of the Solicitor General Canada, *Age and Sexual Recidivism: A Comparison of Rapists and Child Molesters*, (2001), *available at* http://www.blueshifthome.com/Recidivism/studies/Canada%20-%20Age%20and% 20Sexual%20 recidivism%20a %20comparison%20of%20rapists%20and%20child%20molesters%20-%202000-01.pdf, (last visited Aug. 26, 2010).

C.E. Moody, *Prison Population Growth and Crime Reduction*, Journal of Quantitative Criminology 10 (1994), 109-140; *see also* C.A. Visher, *Incapacitation and Crime Control: Does a 'Lock 'em up' Strategy Reduce Crime?*, Justice Quarterly 4 (1987), 513-543. Noted expert James Q. Wilson summarizes these, and similar, findings as follows, "the weight of scholarly opinion is that prison sentences do deter crime Steven Levitt, Daniel Nagin, and other scholars have produced studies that convincingly show that, even after controlling statistically for other factors, a higher risk of going to prison in states is associated with lower crime rates in those states." James Q. Wilson, "Criminal Justice," in Peter H. Schuck and James Q. Wilson (eds.), UNDERSTANDING AMERICA – THE ANATOMY OF AN EXCEPTIONAL NATION, (2008) at 478. For the above reasons, the Prisoner Release Orders not only fail to give "substantial weight" to public safety, they affirmatively threaten public safety.

CONCLUSION

The Court should reverse the determination of the three-judge court, and remand for further proceedings in accordance with guidance from this Court.

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APPELLEE'S BRIEF

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OFFICE OF THE CLERK

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et. al.*,

Appellants,

v.

MARCIANO *PLATA* AND RALPH *COLEMAN*, *et. al.*,

Appellees.

On Appeal from the Three-Judge District Court in
the United States District Courts
for the Eastern District of California and
the Northern District of California

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QUESTIONS PRESENTED

1. Whether the Court has jurisdiction under 28 U.S.C. § 1253 to review the single-judge court's decision to convene the three-judge court and, if jurisdiction exists, whether, given the gravity of the continuing Eighth Amendment violations caused by crowding in California's prisons and the State's manifest failure to remedy the violations despite numerous prior orders over the past eight years, the court abused its discretion when it found that it had afforded the State a "reasonable" amount of time to comply with its prior orders before considering a crowding reduction order.

2. Whether the three-judge court clearly erred in concluding that the conditions for a prison population cap under 18 U.S.C. § 3626(a)(3)(E) were satisfied based on its fact-intensive determinations that (i) prison overcrowding is the primary cause of California's failure to provide inmates with constitutionally adequate mental and medical healthcare, and (ii) in light of numerous unsuccessful previous court orders spanning years of failed remedial efforts, "no other relief" would remedy the ongoing constitutional violations.

3. Whether the three-judge court's order requiring California to bring its prison population to within 137.5% of its prisons' total design capacity, while affording State officials broad discretion to choose which remedial measures will safely and effectively address the prison overcrowding crisis, is narrowly drawn, extends no further than necessary, is the least intrusive means necessary to correct the ongoing violations of inmates' federal constitutional

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JURISDICTION

This Court has jurisdiction over the State's appeal from the January 12, 2010, injunction issued by the three-judge court pursuant to 28 U.S.C. § 1253. However, the Court lacks appellate jurisdiction over the State's challenge to the July 23, 2007, order of the single-judge court, because that order concerns a matter that is required by statute to be decided by a single-judge district court, and it is not an injunction.

INTRODUCTION

Medical care in California's prisons is in crisis despite eight years of judicial oversight. Prisoners are dying unnecessarily at the alarming rate of one every eight days because they do not receive basic medical care from the State. Prisoners are not properly screened for communicable and other serious diseases because there is no space in the overcrowded prisons to do so. If they are properly diagnosed they often do not receive timely medicine because the medication distribution system is so overburdened by the vast number of prisoners in a system designed for half as many. And if they need to see a specialist for a life-threatening condition, such as malignant cancer, they must often wait until it is too late because there are too few specialists for such a large population. Even when prisoners present extreme symptoms, such as recurrent severe abdominal pain and vomiting over a five week period, they are too often left untreated, and die. This appeal demonstrates far too well that "[t]o a prisoner, time behind bars is not some theoretical or mathematical concept. It is something real, even terrifying. Survival itself [is] at stake." *Barber v. Thomas*, 130 S.Ct. 2499, 2517 (2010) (Kennedy, J., dissenting).

The reason why these horrifying conditions have lasted so long and prior judicial orders have been so ineffective is clear – prison overcrowding.

The Governor recognized in 2006 that overcrowding causes "extreme peril" to the lives of prisoners and prison staff, and declared a Prison Overcrowding State of Emergency. The State now concedes overcrowding causes prisoners to suffer deprivations of their Eighth Amendment right to minimally adequate medical care. Former heads of corrections from Texas, Washington State, Pennsylvania, Maine and California all testified that it was the *primary cause*, as did the experts offered by the State, the defendant-intervenors, and plaintiffs.

The court-appointed Receiver overseeing the prison medical system reported that his efforts to provide minimally adequate care cannot be successful with this level of overcrowding. The court came to the same conclusion after trial, finding that "overwhelming evidence" supports the conclusions that the primary cause of the current Eighth Amendment violations is overcrowding and that no other remedy will be successful until that condition is alleviated.

The State offers no hope of any remedy for these intolerable conditions for the indefinite future. Despite the Governor's best efforts to reduce the population by 37,000 prisoners, the legislature has shown little interest in such a politically sensitive subject. As a result, the prisons are about as crowded now as they were when the Governor first proclaimed the State of Emergency, which continues to this day.

Despite the political gridlock that paralyzes California's government on this issue, the State appeals the trial court judgment which provides the only viable avenue to remedy the ongoing violations. The State's appeal does not acknowledge the hard facts identified here and by the trial court, or its own long history of failing to comply with its constitutional obligations.

Instead the State distorts the record evidence beyond recognition, completely ignores the clear error standard of review and seeks from this Court *de novo* review of the evidence. The State's legal positions fare no better. The State mischaracterizes crucial evidentiary rulings of the trial court, and urges on this Court a construction of a key term that is incompatible with the plain language of the statute and that conflicts with the position it took below. The Court should reject these meritless claims.

The three-judge court employed a remedy explicitly approved by Congress, requiring the State to reduce crowding at its prisons over two years. The court did not order the release of a single prisoner. Instead, the order allows the State to reduce crowding by methods of its own choosing, which may include building more prisons, transferring prisoners to other jurisdictions or adopting any of the methods for reducing the population that the Governor recently proposed and that in other jurisdictions have proven to be safe and effective.

The court's order respects the State's right to make policy decisions on how to remedy the grave and harmful conditions. It is the only effective remedy to a prison crisis that has plagued the State for nearly a decade. The judgment of the three-judge district court should be affirmed.

STATEMENT

A. California's Prison System Is "Collapsing Under Its Own Weight."

California's prisons house twice as many prisoners as they were built to hold. They are so overcrowded that they are incapable of performing their essential functions. Lead appellant Governor Arnold Schwarzenegger recently acknowledged that the entire prison system is "collapsing under its own weight." 4 J.A. 1536.[1] That the prison healthcare system is one of the casualties is beyond dispute.

1. The Governor Has Declared A "Prison Overcrowding State Of Emergency."

In 2006, Governor Arnold Schwarzenegger declared a "Prison Overcrowding State of Emergency" because overcrowding "has caused substantial risk to the health and safety of the men and women who work inside these prisons and the inmates housed in them." JS1-App. 61a; 5 J.A. 1694. The State of Emergency is still in effect.

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[1] Cites to "J.A." refer to the Joint Appendix filed by the parties in this case. The record in *Plata*, No. C01-1351-TEH (N.D. Cal.) is cited by docket entry (*i.e.*, "D.E. __"). Cites to "JS1-App." refer to the appendix filed by appellants in Case No. 09-416. Cites to "JS2-App." refer to the appendix filed in support of appellants' Jurisdictional Statement in this case. Trial transcripts are cited as "Tr." and trial exhibits are cited by party and number (*i.e.*, Def. Ex. __ and Plf. Ex. __).

More than ten thousand double and triple bunks are "crammed into gyms and dayrooms that were never meant to be used for housing." JS1-App. 100a. According to a former high-ranking California prison official: "the risk of catastrophic failure in a system strained from severe overcrowding is a constant threat.... [I]t is my professional opinion this level of overcrowding is unsafe and we are operating on borrowed time." JS1-App. 84a-85a.[2]

The former head of the Texas prison system toured California's crowded prisons and declared that "'[i]n more than 35 years of prison work experience, I have never seen anything like it.'" JS1-App. 100a.

In short, because of the dangerous levels of overcrowding, the State has become unable to meet its "first obligation," that is, "to ensure the safety of guards and prison personnel, the public, and the prisoners themselves." *Wilkinson v. Austin*, 545 U.S. 209, 211 (2005).

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[2] Trial exhibits containing vivid depictions of the vastly overcrowded prisons, and the Governor's speeches about them, are reproduced at http://www.rbg-law.com/home-page-2/news/selected-coleman-plata-trial-materials/.

2. The State's Political Process Is Incapable of Meaningful Reform.

Although Governor Schwarzenegger declared in 2006 that "immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding," JS1-App. 61a, the State has still failed to take any meaningful action.

Over the last two decades, the State has convened *more than a dozen* blue ribbon panels to study the prison crisis. JS1-App. 55a. Each panel has come to the same inevitable conclusion: to provide essential services, the State must reduce prison crowding. Each group of experts also made "essentially the same" recommendations about how to reduce crowding. *Id.* These recommendations were ignored. The prison population kept growing, and crowding worsened.

At the same time, the Governor repeatedly urged the State legislature to enact prison population reduction measures. Those measures were rejected or gutted by the legislature. 5 J.A. 1704-1705; 6 J.A. 2456-2457, 2460-2464. In his last major effort in this respect, the Governor proposed a bill in 2009 to reduce the prison population by 37,000 prisoners over two years (essentially the same amount as ordered by the trial court). 4 J.A. 1522-1524. The legislature failed to enact the proposal, and the population is largely unchanged.

It is at this juncture, after every other effort failed, that the Governor described why judicial relief is necessary:

> I don't blame the courts for stepping in to try to solve the health care crisis that we have,

> the overcrowding crisis that we have, because the fact of the matter is, for decades the state of California hasn't really taken it seriously, and hasn't really done something about it.

5 J.A. 1815.

3. Overcrowding Causes Eighth Amendment Violations That Produce Serious Injury And Cost Lives.

Under the Eighth Amendment, the State is required to provide care consistent with "the minimal civilized measure of life's necessities." *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981). Accordingly, the government has an "obligation to provide medical care for those whom it is punishing by incarceration." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

As a direct result of overcrowding, California state prisoners are not provided constitutionally adequate care, resulting in "unacceptably high numbers" of deaths, suicides, and extreme failures to provide basic care. JS1-App. 123a; 5 J.A. 2036-2041; *see also* Cal. Prison Receivership, *Analysis of Year 2009 Death Reviews* at 11-14 (Sep. 2010) ("2009 Death Reviews"), *available at* http://www.cphcs.ca.gov/docs/resources/OTRES_DeathReviewAnalysisYear2009_20100907.pdf (continuing high rate of preventable and possibly preventable deaths at a rate of one every eight days). The State concedes both that it is violating the prisoners' Eighth Amendment right to adequate medical care, and that crowding is one of the causes. *Plata v. Schwarzenegger*, 603 F.3d. 1088, 1097-98 (9th Cir.

2010); Oral argument at 9:53-10:13, *Plata,* Ninth Cir. No. 09-15864, *available at* http://www.ca9.uscourts.gov/media/view_subpage.php?pk_id=0000003923; Tr. 2953:6-2954:5 (closing argument); Tr. 46:17-19 (opening statement).

The following are undisputed findings and supporting facts:

- Prison reception centers, where prisoners are processed on arrival, are currently so crowded that they are unable to properly screen new prisoners. JS1-App. 87a-89a. As a result, serious "health needs are not identified" and "cannot be treated." *Id.* This is a leading cause of prisoner deaths. 5 J.A. 2049; *see also* 2009 Death Reviews at 8-9. For example, one prisoner with "abnormal chest x-rays, shortness of breath, and low oxygen saturation" died after prison medical staff failed "to properly evaluate/manage 'red flag' symptoms . . . ." Def. Ex. 1233 at 14.

- The overcrowded housing units make it nearly impossible for prison staff to identify or respond adequately to medical emergencies. JS1-App. 110a-111a; 6 J.A. 2212-2214. A former head of California's prison system described how a prisoner was assaulted in the middle of a crowded gymnasium converted to overflow housing. Because the gym was so crowded, prison staff didn't even know about the injury – much less provide emergency medical aid – until hours after the prisoner was already dead. 6 J.A. 2214 (Woodford).

- The sheer number of prisoners has overwhelmed the prisons' system for providing medicine to prisoners. As a result, the prisons are unable to deliver the right medication to the right prisoner in a timely manner. JS1-App. 112a-114a; 5 J.A. 2041 (describing prisoner who died after being prescribed the wrong medicine in "error"); *see also* 2009 Death Reviews at 9, 11-15.

- Overcrowding has also overwhelmed the prisons' medical records system, making it "impossible" for the prisons to provide essential healthcare functions appropriately. JS1-App. 118a-121a. For example, one prisoner died after he was discharged from the hospital without any communication between the discharging physician and the receiving physician about his ongoing course of medication. 5 J.A. 2042-2043.

- Overcrowding has also eclipsed the prisons' ability to provide urgent specialty medical care to prisoners who need it. JS1-App. 114a-116a. The need for such care simply "exceeds the capacity of the [available] providers." JS1-App. 114a. This, too, leads to serious harm and death of prisoners. For example, one prisoner was found to have died because of a "five week delay in referral to specialist for patient with recurrent severe abdominal pain, vomiting, and known bilateral inguinal hernias." 5 J.A. 1999; *see also* 2009 Death Reviews at 13 (death could have been prevented by timely specialist care).

- "One of the clearest effects of crowding is that the current prison system lacks the physical space necessary to deliver minimally adequate care to inmates." JS1-App. 85a. As the Receiver has reported, "'available clinical space is less than half of what is necessary for daily operations.'" JS1-App. 93a (citation omitted).

- Because the prisons are so overcrowded, inmate control is difficult, and prison administrators rely heavily on lockdowns to exert control. JS1-App. 116a-117a. During lockdowns, prisoners are unable to leave their housing units to go to health clinics. JS1-App. 117a-118a.

- The overwhelmed medical staff and the excessive lockdowns cause serious delays in the time it takes for prisoners to access essential medical care. JS1-App. 116a-118a. Delayed care can have serious, and often fatal, results. In a review of prisoner deaths in 2007, experts found twenty instances of delays so severe they were considered "sufficient to result in harm to the patient." 5 J.A. 2038. A similarly high number of deaths due to delays in care was found the prior year, 5 J.A. 2001, and last year. 2009 Death Reviews at 9, 11-15. The examples are illuminating. In one case, a prisoner died because of a "two year delay in diagnosis of testicular cancer in . . . patient with chronic testicular pain, [which was] metastatic at time of eventual diagnosis . . . ." 5 J.A. 2000. Another prisoner died after suffering "an 8 hour delay in access to MD evaluation while experiencing 'constant and extreme' chest pain on the day of death." 5 J.A. 1999.

B. The Single-Judge Court Proceedings

Plaintiffs in the *Plata* case filed their complaint in this action in 2001, alleging that the California Department of Corrections and Rehabilitation (CDCR) had failed to provide constitutionally adequate medical care in California's prisons in violation of the Eighth Amendment prohibition against cruel and unusual punishment. D.E. 1, 20.

In 2002, the State conceded that its prisons were violating prisoners' constitutional rights, admitted that judicial oversight was necessary, and stipulated to an injunction designed to provide minimally adequate medical care. 3 J.A. 889-890, 904. The State has never sought to terminate the decree or to end judicial oversight of the prison medical system.

1. *The State Never Complied With The Court's Orders.*

As part of the 2002 stipulated injunction, the State agreed to implement remedial measures at each of its 33 prisons. 3 J.A. 889-891. By 2004, the State had not complied with the order, and court-appointed experts identified an "emerging pattern of inadequate and seriously deficient physician quality" throughout the prisons. 3 J.A. 918-919 (citation omitted).

The State stipulated to further court-ordered relief, including a 2004 order aimed at improving the quality of patient care and reducing serious staffing shortages. 3 J.A. 908-915.

By mid 2005, "not a single prison" had successfully implemented the measures required by the 2002 remedial plan, and the State had utterly failed to comply with the 2004 Patient Care Order. D.E. 294 at 3. The State conceded that the "most" it was able to do was "to attempt to institute some 'stop gap' measures." *Id.* at 8. The court found that "even some of those appear beyond their capability." *Id.*

In late 2005, after a six-day trial, the district court imposed a receivership over the prison medical care system, finding:

> The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system. This statistic, awful as it is, barely provides a window into the waste of human life occurring behind California's prison walls due to the gross failures of the medical delivery system.

3 J.A. 917. The court specifically noted that these failures developed "during a period of exponential growth in the prison population." 3 J.A. 974.

2. *The Receiver Is Unable To Provide Constitutional Medical Care.*

The Receiver faced insurmountable roadblocks as a result of overcrowding.

By 2006, the prisons, built to house approximately 80,000 prisoners, housed double that number. JS1-App. 57a, 9a. Some prison units were (and remain) crowded to 300% of capacity. JS1-App. 10a.

The Receiver's first report to the court, filed on July 5, 2006, states that "systemic longterm overcrowding" may "render the Receiver's assignment difficult, if not impossible, to complete." 3 J.A. 991. "Unless and until . . . the overpopulation experienced system-wide is effectively addressed, the Receiver will be impeded in applying systemic and even some ad hoc remedies to the medical care system." *Id.*

The Receiver's second report, filed on September 19, 2006, described "severe overcrowding" as "the root cause of many of the prison system's ills, including constitutionally-inadequate medical care." 3 J.A. 994.

In February 2007 the Receiver reported in more detail how crowding has "especially adverse consequences concerning the delivery of medical, mental health and dental care" and "interferes with the Receiver's ability to successfully remedy the constitutional violations." 3 J.A. 998, 1029; *see also id.* at 1029-1039. Although the Receiver declared that "[f]ailure is not an option," he also said that "the time this process will take, and the cost and the scope of intrusion by the Federal Court cannot help but increase, and increase in a very significant manner, if the scope and characteristics of CDCR overcrowding continue." 3 J.A. 1052-1053.

After the end of the Receiver's first year in office, he came to understand the impossibility of his task under the severe strains caused by overcrowding. He issued a supplemental report in June 2007 describing how overcrowding impedes his remedial efforts and especially how crowding-caused problems "are now assuming a size, scope and frequency that will clearly extend the timeframes and costs of the receivership and may render adequate medical care impossible . . ." 5 J.A. 1989-1990.

3. *Prison Medical Care Remains Inadequate.*[3]

One hundred and twelve prisoner deaths during the last two years are attributed to inadequate medical care. 2009 Death Reviews at 18.

In an August 2010 report, the California Inspector General reported deficiencies that cut to the core of the medical system. He found that "nearly all prisons were ineffective at ensuring that inmates receive their medications," that prisoners are not seen by medical personnel "for routine, urgent, and emergency medical needs according to timelines set by CDCR policy," that care at both ends of the spectrum – preventative care and urgent specialty care – is inadequate, and that *none* of the prisons updated prisoner medical records appropriately.[4]

The Receiver explained that these failures are the result of overcrowding. 4 J.A. 1653-1656 (Receiver's Amended Fifteenth Triannual Report, Oct. 4, 2010). The prisons continue to be "ineffective at ensuring that inmates receive their medications" even though the quality of the nursing staff has improved, because of "the significant overcrowding within the prisons combined with the high frequency of overcrowding-related custody controls, such as . . . lockdowns, that interfere with medication management processes." 4 J.A. 1654-1655 (citation omitted). "[A]ccess to providers and services is poor" because "the sheer number of inmates at each facility frustrates our efforts to meet the required timelines for access to physicians and specialty providers. There are only so many hours in the day, so many slots for appointments, and so much treatment space available to handle the population." *Id.*

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[3] The State cites extra-record reports to suggest that the constitutional violations have been remedied. This Court's review should be limited to the record before it. Nonetheless, if the Court considers extra-record evidence, it should also consider the recent reports of the State's Inspector General and the Receiver.

[4] Cal. Inspector General, *Summary and Analysis of the First Seventeen Medical Inspections of California Prisons* 2-3 (Aug. 2010), available at http://www.oig.ca.gov/media/reports/MIU/Summary%20and%20Analysis%20of%20the%20First%2017%20Medical%20Inspections%20of%20California%20Prisons.pdf.

The ongoing failures reflect "the overriding challenge of trying to provide medical care in the context of a highly overcrowded prison system where there are too many prisoners for the healthcare infrastructure . . . ." *Id.* at 1655.

C. The Three-Judge Court Proceedings To Address Prison Crowding

1. The Single-Judge And Three-Judge Courts Proceeded Reluctantly And Cautiously.

In November 2006 plaintiffs filed a motion to convene a three-judge court to consider a crowding-reduction remedy. D.E. 561.

The district court did not resolve plaintiffs' motion immediately. It ordered the Receiver to issue a report describing whether overcrowding impacts his remedial efforts. JS1-App. 63a. At the same time, the court urged the State to use this delay to remedy the problems on its own. *Id.*

In July 2007 – more than a year after the Receiver took office, and months after the Receiver reported that crowding has "especially adverse consequences" on his ability to effectuate his remedial plans – the *Plata* court issued an order requesting that a three-judge court be convened. JS1-App. 65a.

The *Plata* court found that all of its previous "order[s] for less intrusive relief . . . [have] failed to remedy" the constitutional violations. JS1-App. 278a-279a; *see* 18 U.S.C. § 3626(a)(3)(A). A reasonable amount of time had elapsed, and the State had proven unable to comply with those orders. JS1-App. 278a-281a.

The court found that "the Receiver will be unable to eliminate the constitutional deficiencies at issue in this case in a reasonable amount of time unless something is done to address the crowded conditions in California's prisons." JS1-App. 286a. Accordingly, as a last resort, the single-judge *Plata* court recommended that a three-judge court be convened. *Id.*

Once constituted, the three-judge court moved cautiously, staying discovery and delaying consideration of plaintiffs' motion for more than seven months to give the State still more time to resolve the prison crisis. JS1-App. 69a-70a. The State again failed to do so.

Even after the trial court had determined that all legal requirements for entering a prisoner release order had been met, the court delayed entering a final order, virtually begging the State to resolve the crisis on its own. 4 J.A. 1518-1519. Again, however, the State failed to take any action.

2. *The Trial*

During the fourteen days of trial, the court heard testimony from nearly 50 live witnesses and more by written testimony, and admitted hundreds of documents into evidence. JS1-App. 70a.

1. Although the State moved to exclude various categories of evidence about current conditions in the prisons, 3 J.A. 1182, D.E. 1574, D.E. 1576, D.E. 1566, D.E. 1559, D.E. 1561, D.E. 1564, the court rejected those motions, and the parties submitted voluminous evidence about existing conditions.

Plaintiffs' medical expert, Dr. Ronald Shansky, conducted extensive tours of the state prisons in 2007 and then again just before trial, spoke with prison staff, interviewed prison healthcare workers and reviewed voluminous medical files. 4 J.A. 1382-1383; 3 J.A. 2232-2235, 2286. His reports and testimony detailed the conditions that he observed. *See, e.g.*, 4 J.A. 1385-1419. His ultimate conclusion based on all the evidence was that "overcrowding is the primary cause of the constitutional violations in the CDCR for *Plata* class members." JS1-App. 129a-130a.

The former Secretary of corrections in California testified that prison overcrowding made it impossible to provide required healthcare. 5 J.A. 1797; 6 J.A. 2209. She explained that "'[o]vercrowding in the CDCR is extreme, its effects are pervasive and it is preventing the Department from providing adequate mental and medical health care to prisoners.'" JS1-App. 84a. The current Secretary of corrections concurred that "'overpopulation makes everything we do more difficult.'" *Id.*

Doyle Wayne Scott, the former director of the Texas Department of Criminal Justice, testified that overcrowding in California prisons "engenders a state of perpetual crisis that causes management failures" and "overwhelms management infrastructure" that is "needed to adequately organize and track prisoner transfers for specialized medical and mental health care and public health related needs . . . ." JS1 App. 82a-83a.

Jeffrey Beard, then-head of Pennsylvania corrections, explained that the overcrowding reverberates throughout the entire complex prison infrastructure, contributing to widespread system failures and impacting the "ability to properly deliver any service" including medical care. 6 J.A. 2144-2147. "[S]evere overcrowding," he said, is "the biggest inhibiting factor right now in California being able to deliver appropriate mental health and medical care." JS1 App. 128a.

Joseph Lehman, who ran state prison systems in Washington State, Maine and Pennsylvania, explained that crowding "is the primary cause of the inability to provide [medical and mental health] services. It's overwhelming the system . . . in terms of sheer numbers, in terms of the space available, in terms of providing healthcare." JS1 App. 127a.

Similarly, the defendant-intervenors' expert David Bennett agreed that the unconstitutional healthcare in California prisons is due to overcrowding, and that a reduction in crowding is necessary in order to provide constitutionally adequate healthcare. 4 J.A. 1499-1500; 6 J.A. 2512, 2516.

The State's mental health expert conceded that the primary cause of the violations is that there are "many more" ill prisoners than the prisons were designed to hold. JS1-App. 138a.

2. The three-judge court devoted approximately half of the trial to consideration of public safety. Key to that examination was an analysis of what happened in other states and localities that have reduced their prison population. Dozens of jurisdictions throughout the country (including within California) have reduced their prison and jail populations without any resulting impact on crime rates. JS1-App. 202a-203a, 6 J.A. 2500-2509.

Although the State argued that a generic "early release" of thousands of prisoners would increase crime, *all the parties agreed* that there are crowding reduction methods available to the State that would have no adverse impact on public safety.[5] Those

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[5] 6 J.A. 2487-2488 (State expert "is confident" that there are safe means for the State to reduce prison population); *see also* JS1-App. 174a, 192a-219a; Tr. 3044:7-9, 3045:5-12 (Law Enforcement Intervenors' closing argument); Tr. 3022:24-3023:11 (District Attorney Intervenors' closing argument); Tr. 3063:10-24 (San Mateo County Intervenors' closing argument); Tr. 1007:21-1008:4 (Intervenor San Diego County Deputy District Attorney); D.E. 1737 § III (Intervenor Stanislaus County Chief Probation Officer); Tr. 2771:4-10 (Intervenor Yolo County Chief Probation Officer); D.E. 1664 ¶¶ 60-80 (Intervenor Sonoma County corrections expert); D.E. 1667 at 5-6 (same); D.E. 1711 ¶¶ 16-20 (Intervenor San Diego District Attorney); D.E. 1745 ¶¶ 17-27 (Intervenor Los Angeles County Sheriffs' Department, Director of Bureau of Operations for

(continued)

measures include building more prison facilities and transferring prisoners to other jurisdictions. They also include reducing the prison population through carefully targeted measures such as diversion and enhanced good time credits for low-risk offenders.

- *Good Time Credits.* The State and plaintiff experts agreed that the State could safely reduce its prison population by granting prisoners more "good time" credits against their sentences.

The Governor has proposed expanding "good time" credits on various occasions over the past two years, 6 J.A. 2460-2463, 4 J.A. 1522-1524, and two separate expert panels convened by the State also proposed reducing the prison population by expanding good time credits, 5 J.A. 1719-1720, 1739-1742, 1757, 1764-1765, as did all independent experts who testified in this case, including experts for defendant-intervenors. D.E. 1664 ¶ 79 (Bennett Report); D.E. 1667 at 1 (Bennett Supp. Report); *see also* D.E. 1676 ¶ 12 (Sonoma County Sheriff-Coroner); Tr. 1015:21-1016:2 (San Diego Deputy District Attorney); D.E. 1698 ¶ 5 (San Mateo County Chief Probation Officer).

- *Diverting Technical Parole Violators.* State and plaintiff experts also agreed that the State could safely reduce its prison population by diverting technical parole violators to alternative sanctions instead of prison.

Technical parole violators are individuals who have violated the terms of their parole, but have not

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Bureau of Offender Programs and Services); D.E. 1698 ¶ 3 (Intervenor San Mateo County Chief Probation Officer).

been convicted of a new offense. JS1-App. 204a-205a.

Diversion of a portion of the State's technical parole violators has long enjoyed the support of the Governor, key State prison officials, and the State's Expert Panel. JS1-App. 206a-207a; Plf. Ex. 328 at 178 (Governor proposal); 5 J.A. 1721-1727 (State's expert panel report), JS1-App. 55a; Plf. Ex. 113 at 75-91 (Governor's Strike Team Report); Plf. Ex. 3 at 31 (California Little Hoover Commission); 5 J.A. 1758 (Deukmejian Report); D.E. 1633 ¶¶ 18-25 (State parole chief); 6 J.A. 2485-2486 (State's public safety expert).

- *Diverting Low Risk Offenders With Little Time To Serve.* State, defendant-intervenor, and plaintiff experts also agreed that the prison population could safely be reduced by diverting certain low-risk offenders from prison. JS1-App. 210a-214a; 6 J.A. 2400-2401 (State expert); D.E. 1667 ¶ 79 (defendant-intervenor expert).

The State has long supported such diversion plans as a safe means to reduce the prison population. *See, e.g.*, Plf. Ex. 780 at 18 (Governor's proposal to convert certain felonies to misdemeanors, so offenders do not go to prison).

- *Expanded Rehabilitation Programs.* In addition, the parties introduced evidence showing that expanding rehabilitative programs would reduce the prison population without adversely affecting public safety. JS1-App. 214a-216a; D.E. 2031 at 44-46.

D. The Three-Judge Court's Orders

On August 4, 2009, the court issued an opinion and order finding that plaintiffs had demonstrated all elements required by the PLRA for issuance of a "prisoner release order."

The court affirmed the findings of the single-judge courts that the State had been given a "reasonable amount of time" to comply with the earlier orders for less intrusive relief, JS1-App. 74a, and found that "clear and convincing evidence establishes that crowding is the primary cause of the unconstitutional denial of medical and mental health care to California's prisoners." JS1-App. 82a.

The court further found that "[r]educing the population in the system to a manageable level is the only way to create an environment in which other reform efforts, including strengthening medical management, hiring additional medical and custody staffing, and improving medical records and tracking systems, can take root in the foreseeable future." JS1-App. 168a (citation omitted).

The court also canvassed the various proposals for "other relief" that were presented by the State and defendant-intervenors, as well as all other evidence on the subject, and found that "all other potential remedies will be futile in the absence of a prisoner release order." JS1-App. 144a-145a.

The court next addressed appropriate relief. Relying on testimony from State prison officials, county jail administrators, the former head of the California prison system, and the former heads of the Texas, Pennsylvania, Washington State, and Maine prison systems, the court concluded that "a cap of no higher than 137.5% is necessary . . . ." JS1-App. 169a, 175a-185a.

The court gave substantial consideration to potential impacts of its order and found that other jurisdictions have safely reduced prison crowding and that California can do the same "without a significant adverse impact upon public safety or the criminal justice system's operation . . . ." JS1-App. 187a-188a.

To reduce crowding, the State "would not be required to throw open the doors of its prisons . . . ." JS1-App. 173a-174a. The State could, for example, increase prison capacity or transfer prisoners to other facilities. Or, it may employ population reduction methods that have already proven successful in other jurisdictions, and have previously been proposed by the Governor. Overwhelming testimony affirmed that there are population-reducing measures that "would not adversely affect public safety." JS1-App. 249a; *see also* JS1-App. 196a-220a.

The court did not find, as the State asserts, that a population reduction "is likely to cause a statistically significant increase in crime" unless the State funds rehabilitative programs. State Br. 8. Rather, the court found that "even if" the State did not fund additional rehabilitation programs, "population reduction could be accomplished without any significant adverse impact on public safety or the operation of the criminal justice system." JS1-App. 187a.

In response to the August 4, 2009, order, the State conceded that it is possible to "safely" reduce prison crowding. JS1-App. 317a. Although the

State's first plan called for reducing prison crowding to 137.5% of capacity by 2013, it submitted a second plan on November 12, 2009, to gradually reduce prison crowding by 2011, using many of the well-accepted, safe methods examined by the three-judge court. JS2-App. 32a-70a. In its November 2009 plan, the State set forth six-month crowding reduction benchmarks. *Id.* 70a.

On January 12, 2010, the three-judge court issued a final order requiring the State to reduce prison overcrowding over a period of two years from the order's effective date. Contrary to the State's suggestion, State Br. 9, the court did not order the State to implement the measures set forth in the November 2009 plan. Rather, the court ordered the State to meet the six-month crowding reduction benchmarks from the State's plan, but gave the State broad discretion to choose which crowding reduction measures it will use to reach those benchmarks. JS2-App. 3a-6a.

The court stayed implementation of its order pending this appeal. JS2-App. 8a-9a.

SUMMARY OF ARGUMENT

This Court is not called upon to resolve the myriad factual discrepancies in the State's brief. Aside from those arguments not properly raised here, the State's brief actually presents only a few straightforward challenges to the trial court's findings of fact, findings which this Court reviews under the deferential "clear error" standard. Fed. R. Civ. P. 52(a)(6). The State has failed to show any clear error, and the order below should be affirmed.

1. This case is not about whether the State is currently violating the Eighth Amendment rights of its prisoners. The State has already admitted that there are current constitutional violations and that while it challenges a particular remedy, it does not seek to terminate judicial oversight.

Nor is this case about whether crowding causes the constitutional violations. The State concedes that the inadequacies in the medical care system are caused in part by prison crowding. 6 J.A. 2084 (opening statement), 6 J.A. 2557-2558 (closing argument). The State's dispute is with the trial court's finding that crowding is the "*primary*" cause of the violations.

The State's legal argument fails because the three-judge court accepted the State's definition of "primary cause." Its arguments here that "primary cause" means "but for" and/or "proximate cause" are inconsistent with its position below and the plain meaning of the statute. The State's factual argument also has no merit because its premise – that the court excluded evidence of current conditions – is false.

The trial court correctly found by clear and convincing evidence that crowding is the primary cause of the constitutional violations and that no other relief will remedy the violations. The State makes no attempt to show that the court's factual findings are clearly erroneous, and the evidence it does cite – out-of-context excerpts plucked from the record – do not undermine the court's findings. To the contrary, the findings are based on the extensive record below, and supported by "overwhelming" evidence that includes the testimony of the appellants themselves as well as their experts.

2. The State's contention that it was not given a "reasonable amount of time" to comply with earlier court orders is similarly misplaced.

The State admits that the *Plata* court had previously issued orders for less intrusive relief that failed to remedy the constitutional violations. What the State disputes is the finding that the State had a "reasonable" amount of time to "comply" with the latest order appointing the Receiver. But by the time of trial, the Receiver had been operating for more than two and a half years, and the trial court found by clear and convincing evidence that "a reduction in the present crowding of the California prisons is necessary if the efforts of the *Plata* Receiver . . . are *ever* to succeed." JS1-App. 158a-159a (emphasis added). That finding is supported by the vast weight of expert testimony, as well as the Receiver's statement – affirmed in four separate reports – that overcrowding "will clearly extend the timeframes and costs of the receivership and may render adequate medical care impossible . . ." 5 J.A. 1989-1990; JS1-App. 66a.

No further delay in addressing the overcrowding crisis is required.

3. The court below had an obligation to resolve the primary cause of current and ongoing federal constitutional violations. It is precisely under the circumstances presented by this case – where individuals continue to suffer constitutional deprivations after decades of attempts at lesser remedies have proven unsuccessful – that the federal judiciary has the most important role to play.

The three-judge court ordered the least intrusive crowding remedy available: it required the State to reduce overcrowding, but left to the State full discretion about which methods to employ. Despite the State's pretense, the order will have no adverse effects on crime rates. Numerous other jurisdictions have safely reduced their prison populations, and the trial court correctly found that the State can employ the same techniques in California to reduce prison crowding without an adverse effect on the public's safety. The court's order in fact mirrors the governor's own proposal to reduce prison crowding by 37,000 prisoners.

ARGUMENT

I. The State Has Been Given A "Reasonable Amount Of Time" To Comply With The Prior Court Orders.

Under the PLRA, a "prisoner release order" may not issue, nor may a three-judge court be convened, unless:

> (i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and
>
> (ii) the defendant has had a reasonable amount of time to comply with the previous court orders.

18 U.S.C. §§ 3626(a)(3)(A), (C), (D).

Both the single-judge and three-judge courts determined that each of these requirements were satisfied. The State challenges only whether the single-judge court afforded the State a "reasonable amount of time to comply" with the court's prior orders, under subsection 3626(a)(3)(A)(ii). This Court does not have appellate jurisdiction to review the findings of the single-judge courts in these cases. *See* Brief of *Coleman* Appellees Sec. II(A); Brief of CCPOA Appellees Sec. I(B)(3). Although the Court has jurisdiction to review the three-judge court's ruling, the State has not raised that issue in its opening brief and thereby has waived any claim of error. Therefore, the Court need not reach this issue at all.

If the Court should reach the merits, the State's argument fails because the lower courts' rulings that the State had a "reasonable" amount of time to comply with the district court's orders is well within the bounds of the courts' discretion. The single-judge and three-judge courts' determinations of "reasonableness" are based on the totality of the circumstances and the full procedural history of this ten-year-old case, including the gravity of the constitutional violations and the State's inadequate efforts at compliance. JS1-App. 65a-67a, 74a. A determination of this kind is entitled to great deference, and should be reviewed only for abuse of discretion. *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 404 (1990). The trial court is best positioned to decide this type of matter. *Id.* at 403. Only deferential review will give the trial court "the necessary flexibility to resolve questions involving 'multifarious, fleeting, special, narrow facts that utterly resist generalization.'" *Id.* at 404 (quoting *Pierce v. Underwood*, 487 U.S. 593, 561-562 (1988)). The State fails to show error under any standard of review.

There is no dispute that the *Plata* court has issued multiple orders for less intrusive relief, in 2002 (3 J.A. 888, order for injunctive relief), 2004 (3 J.A. 908, quality of care order), 2005 (3 J.A. 916, establishing receivership) and 2006 (D.E. 473, appointing individual receiver), and that all previous orders have "failed to remedy" the constitutional deprivations. As the court correctly found, it gave "defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed." JS1-App. 279a (citation omitted); *see also* JS1-App. 74a.

Not only did the single-judge court correctly find that it had given the State a reasonable opportunity to comply with all prior orders, but the three-judge court also found after a full trial that clear and convincing evidence establishes that "a reduction in the present crowding of the California prisons is necessary if the efforts of the *Plata* Receiver . . . are ever to succeed." JS1-App. 158a-159a; *see also* JS1-App. 168a ("no relief other than a prisoner release order is capable of remedying the constitutional deficiencies").

The three-judge court explicitly agreed with and adopted the single-judge court's decision regarding "a reasonable amount of time," finding anew that the *Plata* court has "previously entered orders for less intrusive relief that have failed to remedy the constitutional deprivations . . . despite the reasonable time given to defendants to comply with those orders." JS1-App. 74a.

The Receiver's inability to remedy the constitutional violations in the overcrowded conditions was the critical factor in both the decision to convene the three-judge court in July 2007, more than a year after the Receiver was appointed, and in the three-judge court's August 4, 2009, decision to issue a crowding reduction order. *See, e.g.*, JS1-App 281a (single-judge court: "[h]ad the Receiver reported to the Court that he did not view overcrowding to be a substantial impediment to implementing the reforms required in this case, the Court may well have reached a different conclusion"); JS1-App. 155a (three-judge court: "the *Plata* Receiver has determined that adequate care cannot be provided for the current number of inmates at existing prisons and that additional capacity is required to remedy the medical care deficiencies").

The judgment that the Receiver could not accomplish his assigned task in the absence of a reduction in crowding was supported by abundant evidence, including the opinion of the Receiver, prison healthcare experts, and the former directors of five state prison systems, and was well within the proper bounds of discretion.

The Receiver's reports showed that overcrowding was having an adverse impact on every element of his plans from the outset. The Receiver's first report, filed in July 2006, explained that "systemic longterm overcrowding" may "render the Receiver's assignment difficult, if not impossible, to complete." 3 J.A. 991. His second report, issued two months later, described "severe overcrowding" as "the root cause" of the "constitutionally inadequate medical care." 3 J.A. 994.

The experts concurred. One former head of California prisons testified that because overcrowding compromises every aspect of prison operations, the prisons will "never" be able to provide constitutionally adequate medical or mental health care until overcrowding is reduced. JS1-App. 162a-163a. The former head of Texas prisons testified that unless crowding is substantially reduced, "the state will remain in crisis verging on catastrophe and will remain utterly unable to provide adequate medical and mental health care to the prisoners in its custody." JS1-App. 162a. The then-current head of corrections in Pennsylvania echoed that sentiment, as did the former Secretary of corrections in Maine, Pennsylvania and Washington. JS1-App. 163a. Plaintiffs' medical expert Dr. Shansky, himself a former receiver of the Washington, D.C. jails, likewise agreed that neither the State nor the Receiver can "simultaneously develop a competent medical care system in facilities that lack necessary space and staffing, and address the growing needs of an ever-increasing number of patients." JS1-App. 163a; *see also* JS1-App. 164a-166a (listing additional experts who concurred).

The State's argument that the trial court "wrongly believed" that the State's prior failures alone were enough to warrant a three-judge proceeding, irrespective of the receivership, State Br. 16, is mistaken. Both the single-judge and the three-judge courts considered and rejected any contention that the Receiver could remedy the constitutional violations without a reduction in prison crowding. JS1-App. 155a-156a, 158a-159a, 280a-283a

The State notes that the Receiver has made *improvements* to the prison medical system. Congress, however, authorized a single judge to convene a three-judge court — and a three-judge court to issue a crowding reduction order — when an order fails to "*remedy* the deprivation of the Federal right. . . ." 18 U.S.C. § 3626(a)(3)(A) (emphasis added). The changes identified by the State in its brief — increased healthcare spending, increased staffing, and planning to build new healthcare facilities — have proved insufficient, and the Receiver's latest report identifies the reason: there are simply "too many prisoners for the healthcare infrastructure." 4 J.A. 1655.[6]

The State claims a "reasonable amount of time" had not elapsed between one version of the Receiver's long term plans and the single-judge court's decision to convene the three-judge court. State Br. 16. But the Receiver's plan is not an order for injunctive relief and is not a static document; it is a continually developing set of goals and timelines that the Receiver has drafted and revised regularly over the course of years. *See, e.g.*, D.E. 658 at 3 (May 10, 2007, plan: "a living, growing document" that "encompasses a number of remedial measures begun prior to the Receivership as well as activities initiated by the Receiver"); 3 J.A. 1072 (Nov. 15, 2007, plan is the "second iteration" of the Receiver's plans and sets forth different goals); D.E. 1229 at iv (June 6, 2008, plan sets forth new sets of goals of receivership); 4 J.A. 1653-1656 (describing elements of Receiver's plans that have not been achieved because of overcrowding).

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[6] The Receiver's inability to cure the constitutional violations despite the increase in funding and staffing further demonstrates that crowding must be addressed for the Receiver's work to succeed. Further, the State's boast about increased healthcare spending rings hollow now, since the Governor just cut the prison healthcare budget by $820 million. *See* http://www.ebudget.ca.gov/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf at 16.

By the close of trial, two and a half years into the receivership, the overwhelming evidence showed that no matter how much time is given, the Receiver does not have a reasonable chance of success in California's overcrowded prisons. JS1-App. 155a-156a, 158a-159a. Requiring the trial court to wait even longer before convening a three-judge court or issuing a remedy would serve no purpose.

II. The Three-Judge Court Correctly Found That Crowding Is The Primary Cause Of The Constitutional Violations And That No Other Relief Will Remedy Them.

A. The Trial Court's Findings Are Based On Current Evidence.

The State's "current evidence" argument conflates the three-judge court's statutory obligation to make its findings based on current evidence with a statutory construction that would require the court to re-determine liability during the remedial phase. The State's arguments fail because the PRLA does not require the court in this remedial proceeding to decide liability anew, and the three-judge court did consider all relevant evidence of current conditions before issuing relief.

1. The State argues that when deciding whether to issue a "prisoner release order" the three-judge court must again decide whether the State is violating plaintiffs' constitutional rights. State Br. 27-28.

The State's position is not supported by the language or structure of the PLRA, and would be both impractical and a waste of judicial resources.[7] The PLRA regulates the court's role in various aspects of prison litigation, but it requires a three-judge court in only one circumstance – when a prisoner release order is being considered. The three-judge court correctly held – and the State does not dispute – that the single-judge *Plata* and *Coleman* courts have jurisdiction to determine whether the State is violating plaintiffs' constitutional rights, and, conversely, to terminate relief when the constitutional violations are remedied. JS1-App. 77a-78a.

The position the State takes would vest jurisdiction with both the three-judge court and the single-judge court over the same issue at the same time. In a case such as this where the court has continuing jurisdiction for long periods of time, a construction that required two courts to simultaneously have jurisdiction over liability could result in inconsistent rulings and would most certainly cause duplication of judicial effort. The State points to nothing in the PLRA that would suggest Congress intended such a radical change in the procedure of the federal courts.

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[7] Even if it were correct, it does not matter here since the State conceded after trial that it was continuing to violate plaintiffs' constitutional rights.

2. The State contends that the three-judge court must decide whether to issue crowding relief in light of conditions current at the time of trial. Plaintiffs agree, and the court did just that. The State's contention that the court improperly excluded evidence about current conditions is false. State Br. 27.

Although the court cut short arguments relevant *only* to the question whether the current conditions were constitutional, it left no doubt that it would consider all evidence relevant to the issues before it –the cause of the current violations, and the appropriate scope of relief for them – even when such evidence was also relevant to the existence of continuing constitutional violations. 6 J.A. 2339.

Indeed, the State's experts toured the prisons just weeks before trial, examined prison medical facilities, interviewed medical personnel, prison staff and prisoners, and testified about the current conditions they found. *See, e.g.*, Def. Ex. 1017 at 1-2 [5 J.A. 1864]; Def. Ex. 1020 [5 J.A. 1898-1899]; Tr. 1077-1080, 1192-1195, 1203-1204 [6 J.A. 2396-2398, 2418-2419]. The State introduced exhibits with the most current healthcare statistics available, including information about prisoner deaths, medical and mental health staffing levels, and institutional populations. *See, e.g.*, Def. Exs. 1203, 1233, 1235-1, 1235-2 [5 J.A. 2022-2071]. The State also introduced the reports of the *Coleman* Special Master and the *Plata* Receiver, which included their most current discussion of conditions. *See, e.g.*, Def. Exs. 1098-1100, 1111-1112; JS1-App. 150a; Def. Exs.

1225-1231; JS1-App. 41a; JS1-App. 49a. State witnesses testified at length about current conditions, including the extent of overcrowding, staffing levels, the need to house prisoners in gyms and dayrooms, medication management problems, healthcare expenditures, and prisoner deaths. *See, e.g.*, Def. Exs. 1000-1002, 1004-1008; Tr. 756-767 [6 J.A. 2303-2312], 776-777 [6 J.A. 2320-2321], 787-789, 794, 807-808 (State mental health official); Tr. 836-856 [6 J.A. 2339-2347], 860 [6 J.A. 2351], 864, 880-881 [6 J.A. 2354], 896-897 [6 J.A. 2361-2362], 904-905 [6 J.A. 2364], 910 [6 J.A. 2365], 924-925 [6 J.A. 2367-2368, 2373] (State's Chief Deputy Secretary of Correctional Healthcare Services); Tr. 1671-1673, 1678-1709 (Secretary of Corrections); Tr. 1735-1739, 1762-1763, 1768 [6 J.A. 2477] (State Parole Chief); Tr. 1891-1900 [6 J.A. 2482-2484], 1906-1909, 1915-1917 (Undersecretary of Operations for State prisons).

The State does not point to any evidence that was excluded, which demonstrates both that there was no error and that there was no prejudice. In any event, the State cannot be heard to complain because it was the party that moved to exclude evidence of current conditions at trial. *See* 3 J.A. 1182 (requesting that the court prohibit plaintiffs' experts from gathering evidence of prison conditions in 2008); D.E. 1574 (motion to exclude evidence of the prison overcrowding state of emergency); D.E. 1576 (motion to exclude evidence about prison conditions, including current conditions); D.E. 1566 (motion to preclude testimony of guards, who have direct knowledge of current conditions); D.E. 1559 (motion to exclude evidence about suicides in prison, including current data); D.E. 1561 (motion to exclude all evidence about certain prisons); D.E. 1564 (motion to exclude all evidence about State department that provides mental health care, including current evidence).[8]

3. Underlying the State's claim about "current" evidence is an insinuation that conditions had improved so much that, by the time of trial, there were no longer constitutional violations.[9] There is no factual support for such an allegation, and the recent reports of the Receiver and the State Inspector General make that clear. *Supra* 14-15.

Nonetheless, if the State believes there are no longer any constitutional violations, it has a remedy under Federal Rule of Civil Procedure 60(b)(5)[10] and 18 U.S.C. § 3626(b). To date, however, the State has never accepted the three-judge court's invitation to bring that matter before the single-judge district courts by an appropriate motion. 5 J.A. 1691.

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[8] The State also contends that it was "prohibited" from obtaining the Receiver's testimony at trial. State Br. 28. However, the State did not identify the Receiver as a potential trial witness, or call the Receiver as a witness at trial, *see, e.g.*, 4 J.A. 1496 (State's witness list), and its argument is therefore waived.

Instead of asking the Receiver to testify, the State took a safer route and submitted into evidence the Receiver's reports about the impact of crowding on the delivery of medical care. Def. Exs. 1092-1095 (5 J.A. 1911-1990). Moreover, though it was not permitted a deposition, the State also obtained all of the information from the Receiver that it had sought via discovery (evidence it claimed would constitute "accurate and updated evidence . . . regarding the current status of medical care at CDCR institutions statewide"). D.E. 1436 at 9, D.E. 1450 [3 J.A. 1194-1198] & Def. Ex. 1100.

[9] The State claims that plaintiffs' expert "*admi[tted]*" the lack of violations, State Br. 27, but in fact in the testimony that the State cites, plaintiffs' expert merely agrees to the non-controversial assertion by the State's counsel that "*it is possible* that some units" within some prisons provide constitutionally adequate care. 6 J.A. 2258 (emphasis added).

B. The Trial Court Properly Defined And Applied "Primary Cause."

1. The State concedes that the trial court used the State's proposed definition of primary cause, which is the "cause that is 'first or highest in rank or importance; chief; principal.'" State Br. 32; *see also* 3 J.A. 1212-1215 (State's motion *in limine* regarding definition of primary cause). That is also the dictionary definition of the phrase. 3 J.A. 1213. But the State argues here that primary cause means something else -- though it does not clearly explain its proposed definition. *See* State Br. 30-32 (referring to various definitions of primary cause, including "but for cause," "proximate cause" and one that is very close to the definition it offered below: "'superior or controlling'" cause).

Whatever the State now intends, it is barred from arguing for a new definition under the doctrine of judicial estoppel. *New Hampshire v. Maine*, 532 U.S. 742, 749-750 (2001). The State's position about the definition of primary cause is "clearly inconsistent" with its earlier position in this same case. *Id.* at 750. The State persuaded the three-judge court to adopt its earlier-proposed definition of primary cause, and it thereby gained an unfair advantage because plaintiffs tailored their evidence and argument to the State's legal standard. *Id.* at 749. Even apart from estoppel, the State has waived its argument about the definition of "primary cause." A party waives new arguments and claims by not raising them below. *Yee v. City of Escondido*, 503 U.S. 519, 533 (1992).

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[10] *See Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 378 (1992).

2. Even if the State could propose a new definition for primary cause, its argument fails because the statute uses the term "primary cause," not "but for cause" or "proximate cause" – both of which are standards commonly applied by Congress and the courts in other contexts. The Court should presume that Congress meant what it said, and not impose a different standard here. *BedRoc Limited LLC v. United States*, 541 U.S. 176, 183 (2004). Thus, the Court should interpret the term "primary cause" according to its "'ordinary and popular'" meaning. *Id.* at 184 (quoting *Amoco Production Co. v. Southern Ute Tribe*, 526 U.S. 865, 873 (1999)). As the State itself argued to the trial court, the "ordinary" meaning of "primary cause" – the dictionary definition – is "the chief or principal cause," precisely the definition adopted by the court. 3 J.A. 1213 (State's motion *in limine*).

3. The State contends that the three-judge court "treated 'primary cause' as if it were synonymous with a 'contributory cause,'" State Br. 32, but there is no support for this assertion.

The State points out that the court acknowledged that there are multiple causes of the Eighth Amendment violations in this case. State Br. 32-33. But the existence of other causes does not transform the "chief" or "principal" cause into a "contributory" cause. As the three-judge court correctly found, the PLRA's use of the term "primary" to modify "cause" indicates that Congress understood that there may be multiple causes, one of which is primary. JS1-App. 79a. The State acknowledged below that to satisfy the statute crowding need not be the "only" cause, it must simply be the "biggest cause." 6 J.A. 2559 (State's closing argument). Even the State's new proposed definitions of primary cause – "but for" cause and "proximate" cause – presume the possibility of other, lesser causes. Thus, there is no merit to the contention that a factor cannot be the primary cause simply because there are other causes.[11]

The State further suggests that, buried somewhere in the phrases "primary cause" or "no other relief," is a requirement that curing crowding must by itself remedy all the violations. State Br.

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[11] The statutes cited by the State, State Br. 30 n. 10, further demonstrate that in using the term "primary cause," Congress contemplated that there could be multiple causes of the violations. In Pub. L. No. 110-180, § 2(5), 121 Stat. 2559, 2560 (2008), Congress found that there are two primary causes of "the delay in NCIS background checks." Congress also identified multiple "primary causes" of homelessness (Pub. L. No. 111-22, § 1002(a)(1), 123 Stat. 1663, 1664 (2009) ("a lack of affordable housing and limited scale of housing assistance programs are the primary causes of homelessness"); 42 U.S.C.A. § 14043e (finding domestic violence to be "a primary cause of homelessness"). *See also* 42 U.S.C. § 9607(b) and (c)(2) (referring to "sole[]" cause in one subsection (§ 9607(b)), and "primary" cause in another (§ 9607(c)(2)); 49 U.S.C.A. § 24313 (requiring Amtrak to document both "primary and secondary causes" of accidents).

33-35. The statute, however, imposes no such requirement, and the State's construction would raise serious questions about the statute's constitutionality, because it would prohibit courts from remedying the main cause of a constitutional violation unless the relief would simultaneously resolve all deficiencies.

The three-judge court put it succinctly: "The PLRA does not require that a prisoner release order, on its own, will necessarily resolve the constitutional deficiencies. . . . All that the PLRA requires is that a prisoner release order be a necessary part of any successful remedy. If all other potential remedies will be futile in the absence of a prisoner release order, 'no other relief will remedy the violation.'" JS1-App. 144a (quoting 18 U.S.C. § 3626(a)(3)(E)(ii)). The statute is satisfied when a prisoner release order is *necessary* regardless of whether it is in itself *sufficient* to remedy the violation. JS1-App. 134a.

But in any event, the State's argument is unlikely to have any practical significance in this case. Once the crowding problem is resolved, the State should be able to meet prisoners' healthcare needs as required by the Eighth Amendment. The *Plata* court has already issued numerous orders aimed at improving medical care, through, *e.g.*, "recruitment and retention of qualified personnel, medical leadership, medical equipment, screening systems, systems to track patients with needs, record keeping, and institutional culture." J.S. 20-21. Once crowding is reduced, the Receiver and the State will be able to implement those other orders to cure the constitutional deficiencies. At present, however, it is the crowded conditions in the State's prisons that prevent them from doing so.

4. The above demonstrates that the State's legal arguments about the meaning of "primary cause" have little substance. In reality, however, the State's contentions are directed at the trial court's factual findings on primary cause (even while the State concedes that crowding is a significant cause of the constitutional violations). But the three-judge court's findings, which cannot be overturned except for clear error, are well supported.

The three-judge court found that the "only conclusion that can be drawn from the wealth of clear and convincing evidence . . . is that the unconstitutional denial of adequate medical and mental health care to California's inmates is caused, first and foremost, by the unprecedented crowding in California's prisons." JS1-App. 143a.

That determination required the court to analyze the entire record and make credibility determinations about the various expert witnesses, and it also "involve[d] application of law to fact, which is left to the factfinder, subject to limited review." *Exxon Co. v. Sofec, Inc.*, 517 U.S. 830, 840-41 (1996) (appellant must make "'a very obvious and exceptional showing of error'" to merit appellate review).

Surveying the record, the court found (and the State does not contest) the following facts:

- Crowding causes potentially deadly delays in emergency response. JS1-App.110a-111a.

- Crowding increases the transmission of infectious diseases. JS1-App. 101a-102a.
- Having too many prisoners for the prison infrastructure has crippled the prisons' ability to provide the right medication to the right prisoner. JS1-App. 112a-114a.
- The sheer number of prisoners has overwhelmed the prisons' medical records system. JS1-App. 118a-121a.
- There are not enough medical facilities to provide medical care to the vast number of prisoners who need it. JS1-App. 85a-95a.
- There is no place to properly screen the tens of thousands of new prisoners to see if they have serious medical conditions. JS1-App. 87a-89a.
- There are not enough beds to house medically needy prisoners in appropriate settings. JS1-App. 95a-97a.
- There are not enough medical specialists to treat the large number of prisoners who urgently need specialty care. JS1-App. 114a-116a.
- Crowding-caused lockdowns lead to serious delays in providing medical care. JS1-App. 116a-118a.
- Crowding contributes to an unacceptably high number of prisoner deaths. JS1-App. 142a.

The three-judge court summed up the evidence this way: "[t]he crushing inmate population has strained already severely limited space resources to the breaking point, and crowding is causing an increasing demand for medical and mental health care services, a demand with which defendants are simply unable to keep pace." JS1-App. 140a.

The court's primary cause findings are explicitly supported by both the State's expert and plaintiffs' experts, JS1-App. 129a-130a, 138a, by a former head of California's prison system, JS1-App. 126a, and by the former heads of prison systems in Texas, Pennsylvania, Washington and Maine. JS1-App. 126a-128a. Even the current director of California's prison system, an appellant in this case, acknowledges that "overpopulation makes everything we do more difficult" and "continues to 'severely hamper'" the delivery of adequate medical care. JS1-App. 84a; *see also* 6 J.A. 2458-2459.

The State quotes one out-of-context snippet from a speech given by the Receiver to show that the Receiver can remedy the violations without a crowding reduction order. State Br. 11, 17, 34.[12] The trial court had ample reason not to draw the inference the State suggests. The quoted comment refers to the Receiver's ability to hire medical staff if he has limitless money to spend. In the next breath, the Receiver states "Now, the overcrowding, without a doubt the overcrowding creates additional not just expenses, but complications in providing medical services because frankly everything in the prisons is made more difficult by overcrowding." 4 J.A. 1235-1236. The Receiver's full views on the question are set forth in his formal reports to the court, which, combined with the expert testimony in this case, leave no doubt that overcrowding has prevented him from curing the constitutional violations. *See* 4 J.A. 1653-1656, 5 J.A. 1911-1990 (Def. Exs. 1092, 1094; D.E. 2337-2).

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[12] The State also quotes plaintiffs expert Dr. Shansky in support of that proposition. But Dr. Shansky testified strongly that crowding is the primary cause of the violations, as the district court observed. JS1-App. 129a-130a (quoting Dr. Shansky stating "CDCR's medical delivery system cannot provide a constitutional level of care because the prison system incarcerates far more prisoners than can be adequately treated with the resources, staffing and facilities available in the CDCR. In short, it is my opinion that overcrowding is the primary cause of the constitutional violations . . .").

The State also relies on a brief comment by Judge Henderson before trial, stating that he thought that prison crowding is not the "core issue" in *Plata*, and that the Receivership will continue to be necessary once prison crowding is reduced. State Br. 12, 35. The comment does not undermine the court's ultimate findings, because the "core issue" in *Plata* has always been medical care (though the primary cause of the inadequacies is overcrowding), and the parties agree that the Receivership will still be necessary for at least some time once crowding is reduced. In any event, a statement made by a single member of the panel before any evidence was introduced sheds no light on the correctness of the three-judge court's findings reached after the close of trial.

C. No Other Relief Will Remedy the Violations.

Closely related to the finding that crowding is the "primary cause" of the constitutional violations is the three-judge court's conclusion that "no other relief" will remedy the violations. JS1-App. 144a-145a.

The PLRA defines "relief" as "all relief in any form that may be granted or approved by the court . . ." 18 U.S.C. § 3626(g)(9).

The court canvassed the various proposals for "other relief" that were presented by the State and defendant-intervenors, as well as all other evidence on the subject, and concluded that "clear and convincing evidence" establishes that "the constitutional deficiencies in the California prison system's medical and mental health system cannot be resolved in the absence of a prisoner release order." JS1-App. 145a. As the former director of California prisons testified, unless the State reduces overcrowding, it will "never" be able to provide or sustain constitutionally adequate medical or mental health care. JS1-App. 163a.

Like the "primary cause" findings, the three-judge court's "no other relief" findings are fact-based, and should be reviewed for clear error. Fed. R. Civ. P. 52(a)(6). The State does not claim (much less demonstrate) clear error.

1. The State argues that construction of prisons and transferring inmates to out-of-state prisons are less intrusive remedies that the court could have ordered. State Br. 36.[13] But both of these measures, which increase prison capacity, are ways of complying with the court's order because both reduce crowding. JS2-App. 70a; JS1-App. 154a. Also, an order to transfer prisoners would itself be a "prisoner

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[13] This argument conflicts with the State's contention below that the court has no power to order construction. D.E. 2039 (motion to terminate construction plans).

release order" under the terms of the statute. 18 U.S.C. § 3626(g)(4) (defining "prisoner release order" as one that "has the purpose or effect of reducing or limiting the prison population, or that directs the release from . . . a prison").

In any event, the court had ample reason to doubt that prison construction would resolve overcrowding – and thus remedy the constitutional violations – within any reasonable time. The court correctly found that the State's current construction plans have been plagued by so many years of delays, and have been scaled back so dramatically, that they are not a viable "alternative" to a court order. *See, e.g.*, JS1-App. 149a-154a.

2. The State also argues that hiring additional staff is a "less intrusive form of relief" that would remedy the violations, and that the prisons are fully staffed. State Br. 37-38. If both of these assertions were true the constitutional violations would be cured. Yet that is not the case.[14]

The effect of overcrowding on the prison healthcare system is not just a matter of too many prisoners for the number of doctors. There are also too many prisoners for the entire prison infrastructure, including physical space, medication management and recordkeeping systems, screening processes, appointment scheduling systems, and specialist care providers. Overcrowding also heightens the levels of violence and chaos in the prisons to such a degree that "management spends virtually all of its time fighting fires" and makes "short-sighted decisions that create even more crises." JS1-App. 82a (quoting former head of California prisons).

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[14] The State's claim of full staffing is belied by the record. At the time of trial, the statewide vacancy rate for primary care providers (physicians, surgeons, nurse practitioners, and physician assistants) was 30%. 5 J.A. 2065-2068.

The three-judge court thus correctly found that ordering the State to complete additional hiring, without reducing crowding, would be ineffective. "Even if staff could be hired, they would have almost nowhere to work because CDCR's facilities lack the physical space required to provide medical and mental health care." JS1-App. 154a-155a. The State does not dispute this finding. Nor does the State dispute that, once hired, it is difficult to retain staff: "many potential staff members are unwilling to work" in these overcrowded conditions. *Id.* Moreover, as the Receiver recently reported, despite improved staffing levels, "access to providers" continues to be "poor" because of "the sheer number of inmates . . . There are only so many hours in the day, so many slots for appointments, and so much treatment space available to handle the population." 4 J.A. 1654-1655.

3. The State also argues that the Receiver is an alternative form of relief. [15] Simply relying on the Receivership is not a viable alternative when crowding must be reduced for the Receiver's efforts to succeed. *See supra* 29-33.

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[15] This argument, too, conflicts with the State's argument below that the court has no power to appoint a receiver. D.E. 2039 (motion to replace receiver with special master).

4. After almost two decades of remedial efforts, minimally adequate care in California's prisons remains an unfulfilled promise, not a reality. Improvements have been made, but the systemic violations are far from cured.

The lead appellants in this case – the Governor and the head of California's prison system – both acknowledge that crowding stands in the way of a remedy. They could scarcely assert otherwise. Crowding has caused the plaintiff classes to suffer years of unnecessary death and serious injury. The State continues to offer promises of improvement, but the record convincingly demonstrates that without resolution of the crowding problem the unconstitutional conditions – and the suffering that flows from them – will continue unabated.

III. The Order Below Provides The Least Intrusive Means To Remedy The Constitutional Violations, And Is Narrowly Tailored.

The constitutional violations in this case exist throughout the State prison system. JS1-App. 82a-126a (describing systemwide deficiencies). The State has declared that it is in a statewide "Prison Overcrowding State of Emergency" that requires immediate action to reduce crowding. JS1-App. 61a; *see also* 6 J.A. 2347, 2354 (head of prison healthcare services concedes that "[o]vercrowding has negative effects on everybody in the prison system: inmates and staff, mentally ill, not mentally ill, medical, all of them" and "the impact of overcrowding affects prisoners throughout the prison system"). This is, in short, a case where a systemwide remedy is not just appropriate, it is essential to cure the ongoing constitutional violations.

The three-judge court arrived at an appropriate systemwide remedy consistent with the evidence before it, which included the reasoned opinions of experts who have themselves run state prison systems, and the opinion of the State's own prison facilities chief. JS1-App. 175a-185a. The remedy the court ordered is remarkably similar to the remedy proposed by the Governor himself, who asked the legislature for authority to reduce the prison population by 37,000 prisoners – a reduction that would bring the State almost precisely to 137.5% of design capacity. 4 J.A. 1523.

At trial, the State never countered any of the plaintiffs' evidence or expert testimony establishing the maximum level of crowding at which minimally adequate healthcare could be provided. The State offered no evidence of what it believed to be the maximum capacity; it never argued for or against an order that applied to the system as a whole or to individual prisons; and it never suggested that the use of design capacity as a measurement was improper or that another method would be superior. Instead the State appellants held their tongues, leaving the district court without the benefit of their guidance.

Nonetheless, the court conducted an independent analysis of the evidence before it, rejecting the plaintiffs' proposal to cap the population at 130% of design capacity. Its determination to set the cap at 137.5% of design capacity is the product of a reasonable exercise of informed discretion based upon the voluminous evidence properly before it; as such, it is entitled to deference here.

1. When the three-judge court ordered that crowding be limited to 137.5% of design capacity, it had before it substantial evidence that crowding should be reduced even further. Although the State declined to present any evidence on this subject at trial, its internal evaluation revealed that the maximum capacity of the prisons is 130% of design capacity. The head of the Governor's prison facility "Strike Team" found after considerable study of the question that "the department's longterm goal must be to operate all of its prisons at design bed capacity" (100%), and that 130% of design capacity should be seen only as the "acceptable level of *emergency overcrowding*." 5 J.A. 1783 (emphasis added).[16]

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[16] The State argues that the court's order is not narrowly tailored because the court ordered the State to reduce crowding using "design capacity" as a measure of crowding. State Br. 42-43. Design capacity is the figure that the State itself uses to measure the level of crowding in its prisons. 5 J.A. 2022. Design capacity is a useful benchmark because it measures the available space for all necessary services, not just sleeping space for inmates. Thus, while some cells were designed for one but are large enough for two, the space for health services was designed as if each cell would hold only one prisoner, and the prisons would operate at 100% of design capacity. Def. Ex. 1007 ¶ 72. With double-celling the norm, the State's expert testified, "even the newest of California prisons have inadequate space for care." 6 J.A. 2419.

The State also suggests that the court erred because housing two prisoners in a cell designed for one ("double celling") is not itself unconstitutional. State Br. 42-43. That is a red herring – the court did not even consider, much less find, that double-celling violated the Eighth Amendment.

The former head of California's prison system considered this opinion – along with her own analysis of the prison system based on her decades of employment within California's prisons – to arrive at the conclusion that the maximum level of crowding at which the State could provide adequate healthcare is 130% of design capacity. 4 J.A. 1420-1422; JS1-App. 180a.

Former heads of state prison systems in Texas, Pennsylvania, Maine and Washington – most of whom had been chosen by the State of California as experts to analyze California's prison system – likewise testified that 130% is the crowding level at which the State could provide constitutionally adequate healthcare. JS1-App. 180a-181a.[17] The Texas official testified that when the Texas prisons were severely overcrowded, Texas experienced "much of the same problems" as California, and found itself unable to provide timely or appropriate medical care. Tr. 143:21-144:14. The Pennsylvania expert testified that when his state's prisons were crowded at a level far less extreme than California, healthcare was compromised and "[m]ost of our institutions were having difficulties operating." 6 J.A. 2138-2139; *see also* 6 J.A. 2142 (prison at 200% of capacity not manageable).

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[17] The State sets up a straw man when it contends that plaintiffs chose the 130% figure because it is the federal standard for crowding. State Br. 43. As just explained, a host of credible experts who were intimately familiar with California's prisons determined that 130% was the maximum level of crowding at which adequate healthcare could be provided to California prisoners. The State's prison facilities "Strike Team" considered the federal standard, but it arrived at the 130% figure based on its own "study of the question." D.E. 1995-6 at 94:13-24. Actual crowding levels in BOP prisons – which employ a different measure of crowding – are irrelevant to this case, and no evidence on this point was presented at trial. State Br. 43-44.

The court also considered evidence that called for a higher cap. A panel of experts convened by Governor Schwarzenegger and chaired by former Governor George Deukmejian found that crowding at 145% of design capacity was the "maximum operable capacity" of the prisons. 5 J.A. 1762. That figure does not stand alone because the Deukmejian Report's definition of "maximum operable capacity" did not take into account the resources needed to provide constitutionally adequate healthcare, JS1-App. 181a-182a; *see also* D.E. 1991-6 at 108:3-109:21, and also assumed that the State would stop housing prisoners in gymnasiums, classrooms, dayrooms and hallways, which it has not done. 5 J.A. 1771; Tr. 1919:24-1921:5, 1915:13-1918:7; Def. Ex. 1252-2. Thus, the court found, the 145% estimate "clearly exceeds the maximum level at which the state could provide constitutionally adequate medical and mental health care in its prisons." JS1-App. 182a-183a.

The court nonetheless rejected plaintiffs' proposal to limit the population to 130% because the Deukmejian Report suggests that the medical system "might" be able to provide adequate care with a somewhat higher level of crowding. JS1-App. 181a. The court chose 137.5%, candidly recognizing that "choosing the percentage of design capacity to which the prison population should be reduced is 'not an exact science.'" JS1-App. 175a (citation omitted).

This is true of much of the work that courts must accomplish, and courts must therefore rely upon the evidence before them to craft the narrowest possible remedy. The three-judge court did just that.

The State attempts to undercut the court's findings by showing that plaintiffs' medical experts (who were not asked to analyze the maximum crowding level) could not "assess" the maximum crowding level, State Br. 45-46,[18] and that plaintiffs' correctional experts (who are not medical doctors and were not asked to analyze medical care) were unaware of the particulars of medical care in the prisons. State Br. 47. Nothing in the experts' testimony demonstrates that the trial court clearly erred.

2. The State argues that the three-judge court erred because "[t]here is no basis for a systemwide remedy," State Br. 50, but it omits mention of the trial court's findings on this point.

The three-judge court found that a "systemwide remedy is appropriate" in this case because "the constitutional violations identified by the *Plata* and *Coleman* courts exist throughout the California prison system and are the result of systemic failures in the California prison system." JS1-App. 171a; *see also Lewis v. Casey*, 518 U.S. 343, 357 (1996). The court cited the numerous reports of the *Plata* Receiver and the *Coleman* special master that "document the systemic nature" of the violations. JS1-App. 171a.

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[18] The State quotes Jeanne Woodford, a former head of California's prison system, for the fact that she was unaware of a *study* conducted on this point. State Br. 46. Given her decades of work experience within the State's prisons, including as a warden and as a head of the entire prison system, Ms. Woodford was well qualified to give an opinion on the subject regardless of the existence of a formal study.

The State asks this Court to make a *de novo* finding to the opposite effect based on one sentence from the cross-examination of one of plaintiffs' experts that proves nothing. State Br. 50, *citing* 6 J.A. 2258 (Q. In your opinion . . . *it is possible* that some units in California's prisons are currently providing constitutional levels of care to inmate patients, correct? A. *That's possible*") (emphasis added). The State also attempts to show that conditions in some prisons are better than others. State Br. 52. Such variation shows that conditions are not identical in all prisons, but it does not demonstrate that the violations are not systemic.

3. The State's fallback argument – that principles of federalism prohibit the court's order in this case – is similarly misplaced.

Our federal system requires federal courts to exercise restraint in matters reserved to the states, but it also requires federal courts to take necessary action when states violate the federal constitutional rights of citizens. *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 841 (1995) (Kennedy, J., concurring) ("That the States may not invade the sphere of federal sovereignty is as incontestable, . . . as the corollary proposition that the Federal Government must be held within the boundaries of its own power when it intrudes upon matters reserved to the States").

Here, the State has acknowledged that it is violating the federal Constitution. Its violations pose an immediate and everyday threat to prisoners' lives and health. The federal courts have an obligation under our federal system of government to remedy those violations. *See* Brief of *Coleman* Appellees Sec. I.

The three-judge court made the narrowest ruling possible under the circumstances. It deferred completely to the State to determine the method by which the crowding will be reduced, and hence which prisoners will be affected by its order. JS2-App. 2a-10a; JS1-App. 255a-256a (adhering to *Bounds v. Smith*, 430 U.S. 817, 832-833 (1977) and *Lewis*, 518 U.S. at 361-363).

Nevertheless, the State argues that the order is overbroad because it will result in the release of prisoners who are not members of the plaintiff classes. In fact, the court left it to the State to determine whether the population should be reduced at all and, if it chooses to do so, which prisoners will be affected. Moreover, the State is not required to shorten the confinement time of any prisoners to comply with the order; it is free to construct new prisons or to transfer prisoners to other jurisdictions and private prisons, or it can do some combination of these things. But more generally, the State overlooks the fact that, if overcrowding is the primary cause of a constitutional violation, then the violation can only be remedied by reducing crowding. By authorizing relief from overcrowding when crowding itself is not the constitutional violation, Congress necessarily understood that prisoners who were not directly suffering from the constitutional deprivation might be affected by the relief.

As the three-judge court correctly found, its narrow approach provides "the deference to state expertise required by the PLRA and *Lewis* and limits [the] court's intrusion into 'the minutiae of prison operations.'" JS1-App. 175a (citations omitted). This Court directed the lower courts to employ such an approach precisely because it allows the State to exercise "wide discretion within the bounds of constitutional requirements." *Lewis*, 518 U.S. at 363 (citation omitted).

The State benefitted from the deference and flexibility provided by the three-judge court, and it submitted a plan that would reduce crowding by building more prisons, transferring some prisoners to other jurisdictions, and moderately reducing the number of low-risk inmates in prison (not just class members). JS2-App. 70a. Accordingly, the State cannot substantiate its claim that its prerogatives have been infringed or that principles of federalism have been violated.

IV. The Trial Court's Finding That The Order Can Be Implemented Without Any Adverse Impact On Public Safety Is Supported by Abundant Evidence From The Record.

The PLRA requires courts considering any form of prospective relief to "give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." 18 U.S.C. § 3626(a)(1)(A). Congress did not intend this to be a prohibition against orders that limit prison crowding. When codifying the court's authority to issue a "prisoner release order" Congress understood that circumstances might exist where the law compels a court to issue a "prisoner release order" notwithstanding a potential adverse impact on public safety. "While prison caps must be the remedy of last resort, a court still retains the power to order this remedy despite its intrusive nature and harmful consequences to the public if, but only if, it is truly necessary to prevent an actual violation of a prisoner's federal rights." H.R. Rep. No. 104-21, § 301, at 25 (1995).

The three-judge court took extreme care to perform its obligations under the statute by devoting more than half of the trial and fifty pages of its opinion to the public safety question. JS1-App. 185a-256a. The court demonstrated that crowding in California's prisons can be reduced without jeopardizing public safety, and it gave the State broad discretion to determine how to comply with its order so that public safety could be protected. JS1-App. 248a-249a.

Despite this record, the State argues that the court failed to give public safety substantial weight. The premise of the State's argument – and that of the defendant-intervenors and the State's *amici* – is that the three-judge court ordered the State to *release prisoners*. In fact, the court did not order the release of any prisoners. The order below does not even require the State to cap its prison population -- it requires only that the State reduce prison *crowding*. The State can do that by increasing prison capacity or by transferring prisoners to other prison systems. It can also, if necessary, reduce the prison population by diversion and good time credits (without just "opening the prison gates").

Not surprisingly, no party takes issue with the fact that prison construction and transfers can be accomplished without any adverse impact on public safety. And while the State and its *amici* make various arguments about the safety of reducing the prison population, their briefs do not even allude to the court's findings and the evidence on which they were based.

First, the court found that dozens of jurisdictions throughout California and the nation have implemented prison population reductions; none has experienced an increase in recidivism or crime. JS1-App. 202a-203a, 243a-246a, *see also* 6 J.A. 2500-2509. Thus, the court correctly found, historical data shows that "it is possible to lower the prison population without an adverse impact on crime or public safety." JS1-App. 243a; *see also* 4 J.A. 1244-1265; 5 J.A. 1858-1859; Tr. 2160:20-2162:7; Tr. 2815, 2842. The State does not dispute either of these findings.

The three-judge court carefully reviewed the extensive testimony and evidence presented by State witnesses, intervenors, and plaintiffs, and correctly concluded that the evidence "overwhelmingly showed that there are ways for California to reduce its prison population without . . . an adverse impact [on public safety], and that a less crowded prison system would in fact benefit public safety and the proper operation of the criminal justice system." JS1-App. 248a-249a.

The State's public safety expert, as well as the public safety officials who intervened on the State's behalf, described several methods that the State could use to safely reduce the prison population. JS1-App. 192a-193a ("[t]here was overwhelming agreement among experts for plaintiffs, defendants, and defendant-intervenors that it is 'absolutely' possible to reduce the prison population in California safely and effectively") (quoting defendant-intervenor's public safety expert); *see also supra* n. 5 (all parties agreed at trial that there are safe crowding reduction methods).

These well-accepted population reduction methods include providing additional "good time" credits to prisoners for good conduct and for participation in work or education programs thus shortening their length of stay in prison by a few months, JS1-App. 196a-204a; diverting technical parole violators and low-level offenders away from prison, JS1-App. 204a-214a; and expanding rehabilitative programs JS1-App. 214a-216a; *supra* 19-21. The State could accomplish these programs using its "risk assessment" program to target only those prisoners with the lowest risk of re-offending. JS1-App. 224a (low risk prisoners have 17% recidivism rate).

The State wrongly asserts that the court required the State to implement an unsafe crowding reduction plan "under compulsion of a court order." State Br. 54. In fact, the court did not "order" the State to follow any particular plan to reduce crowding. JS2-App. 5a ("we are not endorsing or ordering the implementation of any of the specific measures contained in the State's plan"). All that the court did was to order the State to reduce crowding at its 33 prisons, using numerical benchmarks that the State proposed in its plan. JS2-App. 5a-6a. The court examined in detail all of the crowding reduction measures identified during trial (including each of the major elements of the

State's plan), and found that safe means exist to reduce the prison population. JS1-App. 248a. That satisfied its burden to give "substantial weight" to public safety matters.

Nor did the court find, as the State argues, that reducing prison crowding without expanding rehabilitation programs would harm public safety. State Br. 54-55. On the contrary, it found that "even if" the state did not fund additional rehabilitation programs, "population reduction could be accomplished without any significant adverse impact on public safety or the operation of the criminal justice system." JS1-App. 187a; *see also* JS1-App. 247a-248a ("We credit the testimony from experts who . . . arrived at the opinion that a population reduction, through a combination of earned credits, parole reform, and diversion, could be accomplished in a manner that preserves public safety and the operation of the criminal justice system"). The court properly left public policy decisions about whether to fund rehabilitation programs in the hands of State politicians.

As the court noted, State officials have proposed various methods to reduce prison crowding, including by reducing the prison population, and have proclaimed that these methods will not harm the public. JS1-App. 197a, 207a, 219a.[19] Yet here the State says those remarks are irrelevant because the proposals were made in response to fiscal concerns. State Br. 54. Quite the opposite. If the State believes a reduction in the prison population is safe when it is looking to save money, surely the same can be said when the goal is to cure constitutional violations and save lives.

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[19] The court also noted that by the State's own accounting it would save more than half a billion dollars per year by reducing the prison population. JS1-App. 251a.

CONCLUSION

The order of the district court should be affirmed.

Respectfully submitted,

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APPELLEE'S
BRIEF

No. 09-1233

IN THE
Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA and RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from the United States District Courts For the Northern and Eastern Districts of California

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RULE 29.6 DISCLOSURE

California Correctional Peace Officers' Association is a non-profit corporation organized under the laws of the State of California. As such, it has no parent, and there is no publicly-held company owning 10% or more of its stock.

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Comment, *Coleman v. Schwarzenegger*, 123 Harv. L. Rev. 752 (2010) 52

Note, *Reviewing the Grant of a Three-Judge Court*, 69 Colum. L. Rev. 146 (1969) 34

STATEMENT OF THE CASE

The only question before this Court is whether the three-judge district court properly ordered that California limit its prison population to 137.5% of the system's design capacity in order to remedy conceded and ongoing Eighth Amendment violations. For more than thirty years, this Court has recognized that states violate the Eighth Amendment's prohibition on cruel and unusual punishment when they fail to provide incarcerated persons with basic health care sufficient to prevent the unnecessary and wanton infliction of pain or death. *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976). During the course of this litigation, the State of California has not disputed that its correctional facilities have long failed to provide these minimal levels of mental health and medical care to the 160,000 inmates being held within them. Nor does the State dispute that overcrowding contributes significantly to these failures.

Appellee-Intervenor California Correctional Peace Officers' Association (CCPOA) represents the 35,000 correctional officers working within California's prison system. These correctional officers are, as the three-judge court found, "essential to providing health care to prisoners." JS1-App. 110a.[1] Among their many responsibilities, correctional officers are the front-line officials who identify medical and mental health conditions among prisoners, escort prisoners to treatment, and oversee clinics to ensure the safety of inmates and staff. CCPOA's members play an integral role in nearly every facet of prison health services. For the reasons described below, and despite their best efforts, CCPOA's members cannot adequately perform these duties given the current state of overcrowding. Based on its members' experience with the day-to-day realities of overcrowding and the resulting medical deficiencies in California's prisons, CCPOA took the extraordinary step of intervening in the three-judge court remedial proceedings on the same side as the plaintiffs.

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[1] Citations to "JS1-App." refer to the Appendix to the Jurisdictional Statement in No. 09-416. Citations to "JS2-App." refer to the Appendix to the Jurisdictional Statement in this appeal. Filings in *Plata*, No. C01-1351-TEH (N.D. Cal.), and *Coleman*, No. CIV-S-90-0520-LKK (E.D. Cal.), are cited by docket entry number (*i.e.*, "*Plata* D.E. __," "*Coleman* D.E. __").

A. Overcrowding And Medical Care Within California's Correctional Facilities

In 2009, when the three-judge court ordered the State to develop a plan to reduce the prison population, California's prisons were operating at approximately 190% of design capacity. JS1 App. 78a. The State does not dispute that overcrowding impedes the delivery of constitutionally adequate health care. *Id.* at 84a. Prison overcrowding prevents the delivery of adequate medical treatment because the number of inmates and lack of space overwhelm the system's capacity. Overcrowding also causes infectious diseases to spread among prisoners and to staff. These systemic difficulties are detailed in the briefs of appellees Coleman and Plata. We highlight here the experiences of correctional officers and their inability, under the circumstances, to facilitate the provision of constitutionally adequate care.

1. California's prisons lack adequate physical space to provide necessary medical care. As overcrowding increases the number of patients who need medical care, it simultaneously results in a cannibalization of space and resources needed to provide that care. As a result, the State's prisons now contain less than half the clinic space needed to treat current inmates. JS1 App. 93a (citing the *Plata* Receiver's 2007 Report).

The shortage of clinical space means that medical staff sometimes have no choice but to turn away inmates who need medical care and should be isolated from other prisoners. This leaves correctional officers to face medical problems they have no resources to handle. During a 2008 influenza outbreak at Chuckawalla Valley State Prison, for example, one correctional officer sent three inmates within his unit to the central infirmary for isolation. Due to a lack of bed space, they were almost immediately sent back. Influenza quickly spread to over half of the 340 inmates in the building, and the unit soon had no other choice than to order a lockdown. 4 Tr. 720-21 (testimony of Correctional Officer Ruben Leija).[2]

As a result of space shortage, medical staff administer health care in conditions that are unsafe and result in health care well below constitutional standards. At the state prison in Solano, the scheduling nurse is assigned to an active examination room, and she frequently must work in the dark so that other practitioners can conduct eye examinations. 4 Tr. at 664 (testimony of Correctional Officer Deborah Rowlett). At Old Folsom State Prison, the triage nurse works from a converted storage closet which previously secured the prison's supply of narcotic drugs and sharp instruments. 3 Tr. 606-07 (testimony of Correctional Officer Gary Benson). These instruments are now contained in separate padlocked boxes, which nurses must open within the reach of four to six inmates who are receiving treatment within the same space. The single correctional officer monitoring this clinic cannot simultaneously monitor all of the secure boxes and the inmates receiving treatment. Attempting to treat prisoners in this inadequate space thus compromises the safety of inmates and staff. *Id.* at 614-16.

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[2] Citations to testimony offered during the remedial trial before the three-judge court that occurred in November and December 2008 will be cited to the transcript volume number and page. For example, Officer Leija's testimony regarding the influenza outbreak appears on pages 720-21 in the fourth volume of the trial transcript.

The lack of space also defeats basic medical protocols regarding patient confidentiality and care, thus substantially undermining inmate and staff safety. Examinations are routinely performed with other patients in the same room or with only a thin curtain partition. JS1-App. 94a. Because of insufficient space for medicine distribution, medications are distributed *en masse* to prisoners in a manner that easily reveals their medical information to other inmates. 4 Tr. 663-64 (testimony of Correctional Officer Deborah Rowlett). To be sure, inmates have limited privacy rights within prison walls. But regardless of individual privacy concerns, the disclosure of stigmatizing illnesses, such as HIV, tuberculosis, and staph infections, leads directly to increased violence against sick inmates, thereby making it more difficult for correctional officers to maintain prison security. Furthermore, when medical staff cannot administer proper physicals or expect honest answers from patients regarding their health, illnesses go undiagnosed and are left to spread to other inmates and staff.

In the mental health context, the number of inmates who need either a suicide-watch bed or a mental-health-crisis bed consistently exceeds the number of such beds available. Correctional officers therefore must place these at-risk inmates in telephone-booth-sized holding cages inside of converted supply closets. While internal prison policies recognize that such cages are not suitable for confining inmates for more than four consecutive hours, officers have no choice but to shuffle prisoners back and forth between these spaces as they wait for beds to become available. 3 Tr. 575-77 (testimony of Correctional Officer Brenda Gibbons).

Finally, California's overcrowded prisons do not have the necessary space to administer and store inmate medical records. Inadequate space also limits the system's organizational capacity, thus leading to medical records that are "unwieldy, rarely organized chronologically and, in general, poorly maintained." JS1-App. 119a (statement of Dr. Ronald Shansky). The danger of poor recordkeeping is even more acute when combined with insufficient medical staff to double check for errors. In her experience in the clinic at the Solano facility, Correctional Officer Deborah Rowlett observed *nearly every day* that inmates would correct nurses as the nurses were about to administer the wrong insulin dosage. 4 Tr. 663. Even a small error in the amount or type of insulin administered can lead to severe health consequences, which is why standard practice requires that two nurses be present for its administration. *Id.* at 662. Without sufficient space and staff to maintain medical records, life-threatening errors are commonplace.

2. Overcrowding in California's prisons causes failures in management, security, and oversight that further undermine the provision of necessary medical care. According to former California Department of Corrections and Rehabilitation (CDCR) Secretary Jeanne Woodford, "[o]vercrowding in the CDCR is extreme, its effects are pervasive and it is preventing the Department from providing adequate mental and medical health care to prisoners." JS1-App. 84a.

Due to overcrowding, inmates are assigned to the next available bed without regard for their specific medical and mental health needs. As a result, inmates who have seizures can be assigned to sleep on elevated bunks of a stacked bed with no rails. 4 Tr. 679 (testimony of Correctional Officer Deborah Rowlett). Correctional officers are often unaware that an inmate is having a seizure until it is too late to offer assistance, and inmates frequently display injuries consistent with falling out of their elevated bunks. *Id.* at 676-77.

In the context of mental health, the necessity of assigning low-functioning and easily victimized inmates to any available bed means that these prisoners can often be assigned to cells with highly predatory inmates. 3 Tr. 564 (testimony of

Correctional Officer Brenda Gibbons). The ensuing violence undermines the safety of both prisoners and staff, especially when repeated throughout an entire psychiatric unit.

Even when specific medical needs are identified, correctional officers' efforts to respond effectively are undermined by the lack of available bed space. System administrators know that Chuckawalla Valley State Prison, on the Arizona border, should not house prisoners on psychotropic medications that make them susceptible to heat-induced health problems. Yet Correctional Officer Ruben Leija watched as one such medicated inmate remained in the facility for three months awaiting transfer, regularly suffering heat induced seizures as a result of 120-degree weather. 4 Tr. 709-10, 713. Other patients have languished for over a year in outpatient mental health units despite needing urgent inpatient psychiatric care. 3 Tr. 563 (testimony of Correctional Officer Brenda Gibbons).

Sufficient correctional staff-to-inmate ratios are essential to enable constitutionally adequate health care. Due to overcrowding, California uses converted gymnasiums to house hundreds of inmates on double- and triple-stacked bunks. In these prison "dormitories" there are normally only one or two correctional officers to supervise approximately 200 inmates. JS1-App. 111a. Under these conditions, "[t]he California prison system lacks sufficient custodial staff . . . to provide prisoners with timely access to [medical] care and still perform other essential [penological] functions." *Id.* at 110a. First, correctional officers often cannot identify medical emergencies. The Governor himself acknowledged in his 2006 Prison Overcrowding State of Emergency Proclamation that overcrowding causes "line-of-sight" problems for correctional officers by inhibiting their ability to observe inmates, which creates a substantial security risk. *See id.* at 61a; *see also* Plaintiffs' Tr. Exh. 1.

Second, once officers become aware of medical emergencies, overcrowding interferes with their ability to respond effectively because they are hamstrung by the crowded and noisy environment, thus preventing communication with other officers while they facilitate medical assistance. 4 Tr. 677 (testimony of Correctional Officer Deborah Rowlett).

As Officer Rowlett testified, when an officer and her partner must deal with a medical emergency (such as an inmate under her supervision who suffered daily seizures), no correctional officer will be available to supervise the other almost two hundred inmates, creating a safety hazard for inmates and staff. 4 Tr. 678-79. It is unsafe to leave hundreds of prisoners supervised by only one officer so that his or her partner can escort a sick inmate to medical care. JS1-App. 110a-111a.

Finally, overcrowding in California's prisons substantially increases the use of lockdowns, which further delay the provision of medical care. JS1-App. at 116a. During lockdowns, correctional officers must individually escort prisoners to medical appointments. Often, correctional officers cannot perform this function in a timely fashion because of their other duties. Simply put, the staffing levels in California's prisoners are not set in anticipation of continual lockdowns. JS1-App. 117a. Lockdowns also result in the cancelation of group psychiatric treatment and, as with medical services, inmates often miss individual psychiatric treatment because there are not enough correctional officers to escort them to appointments. For many inmates who are mentally ill, the stress of being locked down and the simultaneous lack of psychiatric care causes further deterioration and an increase in suicidal tendencies. *Id.* at 118a.

3. Overcrowding also exacerbates the spread of infectious diseases. Assigning prisoners to double- and triple-bunked beds in converted gymnasiums leads to unsanitary conditions that breed sickness among inmates and staff. JS1-App. at 100a-102a. In his Emergency Proclamation, Governor Schwarzenegger declared that the overcrowded conditions of California's prisons leads to an "increased, substantial risk for transmission of infectious illnesses." *Id.* at 61a; *see also* Plaintiffs' Tr. Exh. 1 at 1-2. This rampant spread of disease causes healthy inmates to become sick in a system that cannot respond to their medical needs.

Prison administrators have neither space nor organizational capacity to quarantine inmates with antibiotic-resistant staph infections. Instead, prisoners with this highly contagious condition share crowded communal areas such as showers and waiting areas with other inmates. 3 Tr. 604-05 (testimony of Correctional Officer Gary Benson). The same is true for spread of tuberculosis, including drug-resistant tuberculosis.

Communicable diseases also spread to correctional staff. For example, Officer Gary Benson had to undergo two invasive surgeries to address antibiotic-resistant staph infections he contracted while working in the triage clinic at Old Folsom penitentiary. 3 Tr. 605; ***Plata*** D.E. 1669. The State attempts to prevent such inmate-to-staff spread of disease by directing correctional officers to don rubber gloves and to change them between each inmate interaction, a near impossibility for correctional officers monitoring several hundred inmates at once. Such stop-gap measures fail to prevent the spread of diseases and cause tension with inmates who find the procedure demeaning. 4 Tr. 697-98 (testimony of Correctional Officer Ruben Leija).

Moreover, in their unsuccessful struggle to avoid infection, prisoners engage in dangerous behavior which further promotes the spread of disease. For instance, inmates are so anxious to avoid intermingling their clothes with those of infected inmates that many try to launder their clothes in their cell toilets, thereby risking other health problems and failing to effectively sanitize their clothes. 3 Tr. 570 (testimony of Correctional Officer Brenda Gibbons).

Ironically, the danger of contracting infectious diseases rises when prisoners seek out medical care for conditions they already have. At Old Folsom, for example, inmates seeking treatment wait in a twelve-by-twenty foot holding cage built to hold twenty inmates. But normally twice that number are confined there for hours awaiting treatment. 3 Tr. at 597-99 (testimony of Correctional Officer Gary Benson). As they wait to receive treatment for drug-resistant tuberculosis, many inmates cough continually on their neighbors. Prisoners seeking treatment for staph infections are routinely bleeding or oozing pus through their clothes as they wait. *Id.* at 601. Many inmates avoid seeking medical care altogether to avoid this prolonged exposure to other sicker inmates, thus further exacerbating the spread of unidentified and untreated illnesses.

In sum, CCOPA members' daily work experiences reveal an overcrowded, inadequately staffed system that cannot deliver adequate medical care in spite of the best efforts of prison employees. As Correctional Officer Gary Benson explained at trial, there are "way too many inmates in that small of a space to do the job." 3 Tr. at 601.

B. The Special Three-Judge Court Provisions Of The Prison Litigation Reform Act

In 1996 Congress passed the Prison Litigation Reform Act (PLRA), Pub. L. No. 104-134, tit. VIII, 110 Stat. 1321, 1321-66 (1996), to establish detailed statutory standards governing prison conditions litigation. While the Act does restrict prisoners' ability to bring suit or obtain particular remedies, the PLRA also expressly recognizes that under appropriate circumstances federal courts can order a limitation on prison crowding to remedy a constitutional violation. 18 U.S.C. § 3626(a)(3).

The PLRA defines any such limitation as a "prisoner release order" ("PRO") without regard to whether that order actually requires releasing inmates. *See* 18 U.S.C. § 3626(g)(4) ("the term 'prisoner release order' includes any order" having "the purpose or effect of reducing or limiting the prison population," as well any order directing "the release from or nonadmission of prisoners to a prison").[3] The order at issue in this appeal is a PRO because it "effect[ively] limit[s]" California's prison population to 137.5% of the system's design capacity. The State, however, may achieve that ratio through a combination of policies that either reduce the number of inmates within the system or increase the system's capacity. Therefore, we refer to the three-judge court's order as a "capacity limit order" to distinguish it from other types of orders that fall within Section 3626(g)(4).

Section 3626(a)(3) details the procedural and substantive requirements for issuing any Section 3626(g)(4) order. First, the Act authorizes only specially-convened three-judge district courts to enter PROs. 18 U.S.C. § 3626(a)(3)(B). The PLRA presupposes that, faced with prison conditions that violate the Eighth Amendment, single-judge district courts will issue remedial orders designed to cure the violations. If such orders for "less intrusive relief" have "failed to remedy" the constitutional violation, *id.* § 3626(a)(3)(A)(i), even after "the defendant has had a reasonable amount of time to comply," *id.* § 3626(a)(3)(A)(ii), only then may the single-judge court convene a three-judge panel. *Id.* § 3626(a)(3)(C) (providing that any "party" may move to convene three-judge court); *id.* § 3626(a)(3)(D) (providing that a single-judge district court may *sua sponte* convene a three-judge court). Proceedings to determine whether to enter a PRO take place before the three-judge court; the single-judge district court retains jurisdiction over other aspects of the ongoing litigation.

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[3] Congress has also used the more precise term "inmate population ceiling" to refer to such orders. *See* Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, § 20409, 108 Stat. 1796, 1827 (formerly codified at 18 U.S.C. § 3626(b)) (amended 1996).

Once a three-judge court is convened, the PLRA provides that the panel "shall enter" a PRO "only if the court finds by clear and convincing evidence" that two conditions are met. 18 U.S.C. § 3626(a)(3)(E). First, the court must find that overcrowding is "the primary cause" of the constitutional violation requiring remediation. *Id.* § 3626(a)(3)(E)(i). Second, the court must find that "no other relief will remedy the violation." *Id.* § 3626(a)(3)(E)(ii).

C. The Procedural History Of These Cases

1. The consolidated case before this Court originated in two long-running lawsuits challenging the provision of health care in the California prison system. The *Coleman* class action, filed in 1990, involves delivery of constitutionally inadequate mental health care. JS1-App. 32a. *Coleman* entered its remedial phase in 1995 after a single-judge district court determined that California failed to provide constitutionally adequate care to inmates with serious mental disorders. *Id.* at 31a-36a. The *Plata* class action, filed in 2001, involves the State's failure to deliver constitutionally adequate medical care. *Id.* at 13a. *Plata* entered its remedial phase almost immediately after the case was filed because California stipulated that medical health care conditions within its prisons violated the Eighth Amendment's prohibition on cruel and unusual punishment. *Id.* at 14a. The extensive remedial proceedings before the *Plata* and *Coleman* single-judge district courts are set out in the briefs filed by

the two appellees. Although the *Coleman* litigation has been in the remedial phase for over fifteen years, and the *Plata* litigation has been in the remedial phase for over eight, the California prison system has yet to provide constitutionally adequate mental and medical health care.

While the *Coleman* and *Plata* lawsuits were ongoing, the population of California's prisons exploded, reaching an all-time record of more than 160,000 inmates in 2006. JS1-App. 9a. This dramatic increase in the prison population was not accompanied by a commensurate expansion of space or other resources, including sufficient staff, essential to providing constitutionally adequate care. As a result, by 2006, the majority of California's prisons operated at 200% of design capacity. *Plata* D.E. 719 at 5.

In light of unprecedented overcrowding and the State's failure to cure its health care violations through compliance with previous remedial orders, in November 2006 the plaintiffs in each suit separately moved, pursuant to 18 U.S.C. § 3626(a)(3)(C), for appointment of a three-judge court to consider a PRO. JS1-App. 63a. CCPOA filed an *amicus curiae* brief in support of convening a three-judge court, arguing that the "day-to-day impact of overcrowding" was "getting worse," *Plata* D.E. 719 at 8, and that the State had proved unwilling or unable to "meaningfully address" the problem. *Id.* at 7. CCPOA emphasized that overcrowding had reached crisis levels, creating "increasingly unsafe conditions for inmates and employees in all of California's prisons." *Id.* at 3.

After several months of extensive briefing and argument, the *Coleman* and *Plata* single-judge district courts conducted a final combined hearing to consider plaintiffs' motions. JS1-App. 65a. In July 2007, each court separately issued an order finding that the PLRA's requirements for convening a three-judge panel had been met. *Id.* at 273a; *id.* at 288a. Both courts emphasized that overcrowding had prevented prior remedial orders from eliminating the unconstitutional defects in mental and medical health services. *Id.* at 281a-283a; *id.* at 296a.

Following the designation of the three-judge court, CCPOA moved to intervene in the proceedings. CCPOA argued that "[e]very person CCPOA represents has a direct and substantial adverse experience, every day and night that he or she is on the job, as a result of severely overcrowded prison conditions." *Plata* D.E. 828 at 5. In particular, CCPOA emphasized the mental toll on members as a result of their daily inability to prevent unconstitutional conditions. *Id.* at 8. It further noted that several correctional officers had themselves contracted infectious diseases as a result of overcrowding. *Id.* at 7. The three-judge district court, finding it was "apparent that the membership of the CCPOA is significantly affected by the conditions in California's prisons," granted CCPOA's motion. *Coleman* D.E. 2427 at 5.

3. Once convened, the three-judge court encouraged the parties to reach a settlement through mediation. JS1-App. 69a-70a. Only after those efforts failed did the three-judge court embark upon the ensuing proceedings and trial. At trial, CCPOA presented evidence, including testimony by six

correctional officers, that extreme overcrowding in the California prison system made it impossible for its members to facilitate the provision of constitutionally adequate health care to inmates under their control or otherwise to perform their duties effectively. 3 Tr. 503-614; 4 Tr. 657-722.

Following trial, the three-judge court issued a lengthy and detailed opinion that found overcrowding to be "the primary cause" of California's constitutional violations. JS1 App. 82a. It further found that "no other relief" could remedy the problem. *Id.* at 145a. The court therefore ordered that the State develop a plan to bring the prison population to no greater than 137.5% of design capacity within two years. *Id.* at 169a. After the three-judge court rejected the State's first plan for failure to comply with the order, *Plata* D.E. 2269, the State submitted a second plan which included six-month benchmarks for achieving the required capacity ratio. JS2 App. 3a-6a. The court then ordered the State to achieve the necessary reductions in accordance with these benchmarks, but it left the State free to comply through policies of its choosing. In sum, the capacity limit order does not require the actual release of any prisoner, and it provides California with substantial discretion regarding implementation methods, including the option of increasing prison capacity in order to comply with the Constitution.

SUMMARY OF ARGUMENT

Under the circumstances of this case, the Prison Litigation Reform Act authorized the convening of a three-judge court and the issuance of a remedial order capping the population in California's prisons at 137.5% of their design capacity.

I. Based on their years of experience with California's failure to remedy conceded Eighth Amendment violations, the district courts in *Plata* and *Coleman* properly convened a three-judge court to consider ordering a capacity limit on the State's prisons. The PLRA provides for three-judge courts when a district court's previous orders have failed to remedy the constitutional violations even after the State has been given reasonable time to comply with them. In this case, the State does not dispute as a matter of fact that the district courts in *Plata* and *Coleman* each had issued previous less intrusive orders to remedy the violations; that the State was given reasonable time to comply with those orders; and that those orders failed to remedy the violations. Instead, the State argues that a three-judge court should not have been convened, because the single-judge district courts issued additional relief orders in 2006 and 2007.

To the extent that the State's position would permit delaying the convening of a three-judge court in cases, such as this one, where the new orders cannot remedy the constitutional violation, its argument fails as a matter of statutory construction. The language of Section 3626(a)(3)(A) requires such a delay only with respect to orders that direct the "defendant" — as opposed to some other party — "to comply" and only with respect to orders that can "remedy the deprivation of the Federal right." Neither of those conditions is met by the 2006 and 2007 orders to which the State points. Some of those orders are not directed at the State, and thus fall outside Section 3626(a)(3)(A)(ii). Others, as the single-judge district courts found, could at most provide only partial alleviation of the unconstitutional conditions, and thus fall outside Section 3626(a)(3)(A)(i).

Not only is the State's argument unsupportable as a textual matter, but it would undermine the proper functioning of the PLRA. In cases where a federal district court correctly concludes that a three-judge court should be convened, the State's position would compel the court to choose between two unacceptable alternatives. Either the court would have to forgo addressing discrete elements of a systemic constitutional violation in order to avoid triggering a new period for compliance, or, if the court orders such relief, it would needlessly delay the convening of a three-judge court.

In any event, the proper question before this Court is whether the capacity limit order issued by the three-judge court should be affirmed, and not whether the three-judge court should have been convened in the first place. The structure of the PLRA shows that only the three-judge court's orders, and not its constitution, are subject to review on appeal. Moreover, any challenges to the composition of the court were waived and are meritless.

II. The three-judge court correctly held that overcrowding is "the primary cause" of the ongoing constitutional violations in this case. The court properly interpreted the phrase according to its ordinary meaning – that is, as referring to the most fundamental obstacle to providing a complete remedy. The court then found, based on overwhelming evidence, that overcrowding is the most important factor contributing to California's inability to provide constitutionally adequate care. Because the prison population so exceeds design capacity, disease is rampant; inmates are housed without regard for their medical conditions; correctional staff cannot effectively monitor inmates' health problems or deliver them for timely treatment; and clinic facilities are overwhelmed, leading to treatment that falls far below constitutionally adequate standards.

Unable to dispute the factual underpinnings of the three-judge court's decision, the State instead offers a strained reading of the term "primary cause." It argues that the PLRA uses that phrase as a term of art purportedly to impose an elevated level of causation requiring proof that reducing crowding is not only necessary but will also be sufficient by itself to remedy the constitutional violations. The State's argument finds no support within the Act itself, which refers to "primary" rather than "sole" cause. Nor is there any indication in the legislative history that Congress intended to impose such an unusual definition. To the contrary, the State's definition would create serious constitutional problems by foreclosing remedies to address overcrowding, even when constitutional violations cannot otherwise be remedied. It would thus undermine the overall structure of the PLRA, which recognizes that although PROs may be a last resort, they remain available when necessary.

III. Once it was clear that no relief other than an order directed at overcrowding could remedy the constitutional violations in California's prison system, the three-judge court issued an order that complied with the specific requirements for all relief orders under the PLRA. First, as the Act requires, the order was narrowly tailored. By setting a capacity limit, rather than directing the release or transfer of particular inmates, the order left the State with broad discretion over how to achieve the required ratio. The specific ratio the three-judge court set – 137.5% of the system's design capacity – rested on careful consideration of the evidence presented. The State did not identify a more narrowly tailored alternative that could cure the violation.

Second, as the Act requires, the three-judge court gave substantial weight to public safety in crafting its remedy. Particularly given the State's proposals to reduce inmate population to a similar degree for budgetary reasons, the State has provided no grounds for rejecting the three-judge court's finding that a capacity limit is consistent with the PLRA.

ARGUMENT

I. In Light Of The Failure Of Their Prior Orders To Remedy The Constitutional Violations In These Cases, The *Plata* And *Coleman* Single-Judge District Courts Properly Convened A Three-Judge Court.

The PLRA allows plaintiffs to move for the convening of a three-judge panel if (i) prior remedial orders have failed to remedy the constitutional violation, and (ii) "the defendant has had a reasonable amount of time to comply with the previous court orders." 18 U.S.C. § 3626(a)(3)(A). Appellants do not dispute that in 1995 and 2002, the single-judge district courts in *Plata* and *Coleman* had each "previously entered an order for less intrusive relief that ha[d] failed to remedy the deprivation" of inmates' Eighth Amendment rights. 18 U.S.C. § 3626(a)(3)(A)(i). Nor do appellants dispute the findings of the single-judge courts in *Plata,* JS1-App. 279a, and *Coleman, id.* at 296a-297a, that the State had been given reasonable time to comply with these orders. *See* State Br. 16.

Nevertheless, appellants argue that the three-judge court was prematurely convened because the State was not given "a reasonable amount of time to comply" with more recent orders issued by the single-judge district courts in 2006 and 2007. In other words, they assert that these new relief orders triggered a compliance period during which the three-judge court could not be convened.

Appellants' argument contravenes the text and structure of the PLRA, and it would require federal courts to act in ways that Congress could not have intended. Once a single-judge district court concludes that the State has been given reasonable time to comply with its previous orders to remedy the violation and that the constitutional violation cannot be cured without limiting a prison system's capacity, additional orders for partial relief do not require new time for compliance before a three-judge can be convened.[4]

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[4] The *Plata* appellees offer a complementary interpretation of Section 3626(a)(3)(A)(ii). They argue that whether the State has been given "a reasonable amount of time to comply with the previous court orders" depends on evaluating state compliance throughout the litigation. A recent order by a single-judge

A. The PLRA Does Not Require Delay In Convening A Three-Judge Court To Allow Compliance With Orders That Will Not Fully Remedy The Constitutional Violation.

The *Plata* and *Coleman* district courts properly applied the statutory prerequisites for convening a three-judge court. Under the PLRA, a three-judge court should not be convened until "the defendant has had a reasonable amount of time to comply with the previous court orders." 18 U.S.C. § 3626(a)(3)(A)(ii). The reasonable time provision expressly refers only to "orders" with which the "defendant" must "comply." Moreover, read in context, the phrase "the previous court orders" refers only to those orders described in the preceding sentence – specifically, orders that may remedy the violation. In other words, orders that improve conditions somewhat but cannot be expected to fix the constitutional violation do not trigger the "reasonable time" provision. Therefore, under the PLRA, a single-judge district court may convene a three-judge panel even while continuing to attempt improvements through ameliorative orders, so long as those orders cannot by themselves fix the constitutional violation.

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court, therefore, does not mandate additional time for compliance because the State has been given reasonable time overall to remedy the constitutional violation. *Plata* App. Br. 29-35.

Under either of these interpretations, the three-judge court was properly convened. Moreover, both approaches avoid the absurd consequences that would follow from appellants' interpretation.

1. Before convening a three-judge court, Section 3626(a)(3)(A)(i) requires a district court to have "previously entered an order for less intrusive relief that has failed to remedy the deprivation of [a] Federal right." The statute uses the word "remedy," rather than "reduce," or "lessen," or "ameliorate." Thus, as appellants implicitly acknowledge, only a judicial decree that "may cure" a constitutional violation, State Br. 16, satisfies the condition in Section 3626(a)(3)(A)(i) for convening a three-judge court. By contrast, a merely palliative order – such as an order to hire additional nurses in a system where several factors beyond staffing shortages make it impossible to provide adequate care – would not meet that condition.

2. Section 3626(a)(3)(A)(ii) imposes a waiting period to give defendants reasonable time to comply with "the previous court orders." The structure of the statute demonstrates that "the previous court orders" are those orders described in Section 3626(a)(3)(A)(i) – that is, orders that may "remedy" the violation.[5]

By contrast, appellants take the position that *all* previous court orders directed at a constitutional violation trigger the period provided in Section

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[5] Orders under the PLRA need only be narrowly tailored to the violation and do not have to be, by themselves, sufficient to "remedy" the violation. There may be instances where a court realizes early on that prison overcrowding prevents any "less intrusive" order from remedying the constitutional violation. In such instances, Section 3626(a)(3)(A)(i) still requires a single-judge district court to issue a less intrusive order before convening a three-judge court. Thus, a state will always have reasonable time to remedy the violation before a three-judge panel is convened.

3626(a)(3)(A)(ii). State Br. 11. Under this view, every time a single-judge district court issues any relief order in a prison conditions case, it restarts the clock on when a three-judge court can be convened.[6] This restart occurs even if the district court's new order cannot possibly result in fully remedying the Eighth Amendment violations. In such situations, appellants' interpretation would lead to perverse results that Congress could not have intended. District courts would be forced to choose between two unacceptable options. They must either forgo entering *any* ameliorative orders, or, by entering such orders, they must needlessly wait before they can pursue the only avenue capable of fully curing the violation.

For example, suppose overcrowding is the primary cause of unconstitutional health conditions in multiple prisons within a state system and that the state has been given reasonable time to comply with previous orders to remedy the violation. In such a situation, the statutory preconditions for convening a three-judge court have been met. But suppose further that on the eve of requesting the designation of a three-judge court, the district court learns that one facility within the system has antiquated equipment for sanitizing dishes and prisoner laundry. *Cf. e.g.*, *Wyatt v. Stickney*, 344 F. Supp. 373, 382 (M.D. Ala. 1972) (responding to constitutionally inadequate conditions in a state mental hospital connected to the failure to provide sufficiently hot water for patient use, dishwashers and laundry facilities), *aff'd in relevant part sub nom. Wyatt v. Alderholt*, 503 F.2d 1305, 1307 (5th Cir. 1974). An order to update the water system at the single prison might be necessary to protect the health and safety of inmates in that particular facility, yet that order could not fix the systemwide constitutional violation. Under appellants' interpretation of the PLRA, however, the court would either have to withhold ordering any relief relating to the water system in order to convene the three-judge panel, or it would have to wait a reasonable amount of time for the state to replace the single facility's water system before a three-judge court could be convened. That result makes no sense and could not possibly be within Congress's intent in passing the PLRA.

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[6] Of course, convening a three-judge court does not relieve the State of its duty to comply with existing relief orders or its right to have reasonable time to do so. The structure of the PLRA, which delegates the question whether to grant a PRO to a three-judge court, while leaving all other issues before the single-judge court, means that there will often be parallel proceedings. The fact that a three-judge court is underway does not change a state's obligations with respect to orders issued by the single-judge court.

Appellants' reading also leads to absurd results even after a three-judge court properly convenes. It is unclear whether, under Section 3626(a)(3)(A), reasonable time must be given to comply with a single-judge district court's orders after the three-judge panel convenes but before entry of a PRO. The unreasonableness of appellants' argument is apparent regardless of how one answers that question.[7]

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[7] *See infra* at 32-34 (showing that that these conditions are merely procedural and should not be reviewed after the three-judge panel convenes).

a. If the "reasonable time" provision applies after the three-judge panel convenes, then appellants' proposed rule would temporarily suspend the three-judge panel's authority to enter a PRO each time the single-judge district court enters a relief order. This result would obtain even if the new order *could not*, by itself, remedy the constitutional violation. For instance, referring to the hypothetical already described, if the single-judge district court ordered that the single prison's water system be updated after the three-judge panel convened, that order would delay the three-judge panel's authority to issue a PRO. This result makes no sense. Moreover, it is inconsistent with the structure of the PLRA, which gives authority over PROs to three-judge courts, 18 U.S.C. § 3626(a)(3)(B), while leaving the resolution of the many other remedial issues that inevitably arise in prison litigation in the hands of single-judge district courts, 18 U.S.C. § 3626(a)(1), (2). In fact, the single-judge district courts in *Plata* and *Coleman* have each issued dozens of orders since the three-judge court was convened.

b. By contrast, if the "reasonable time" provision does not apply after the three-judge panel convenes, the State's position is untenable for a different reason. Under the State's interpretation, whether the three-judge panel has jurisdiction to enter a PRO would depend on the technicality of whether the single-judge court's recent orders came before or after the three-judge court was convened. For example, if a single-judge district court entered a relief order a week *before* convening the three-judge panel, that panel would supposedly lack jurisdiction. But if the single-judge district court issued precisely the same relief a week *after* convening a three-judge panel, then the panel would have jurisdiction. There is no reason to think that Congress intended such nonsensical distinctions.

B. The More Recent Orders Of The Single-Judge District Courts Appointing The Receiver In *Plata* And The Special Master In *Coleman* Did Not Require Delay In Convening A Three-Judge Court.

Of the recent orders from 2006 and 2007 that the State contends precluded convening a three-judge court, none was capable of curing the constitutional violations.

1. The text of the PLRA provides no basis for delay here. Some of the district court's actions that appellants claim should have restarted the waiting period did not fit within Section 3626(a)(3)(A)(ii) because they did not require the defendant to "comply" with an order. First, appellants suggest that "the remedy of Receivership" restarted the clock. State Br. 15. But establishing a Receivership does not, by itself, create any obligation with which the defendant must "comply." *Cf. Coleman v. Wilson*, 933 F. Supp. 954, 957 (E.D. Cal. 1996) (distinguishing between "the remedies required to cure the constitutional deficiencies" and "the appointment of a special master").[8] Next, appellants argue that the Receiver's submission of a preliminary plan in May 2007 should also have restarted the clock. *See* State

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[8] To be sure, other aspects of the order that appointed the Receiver did place obligations on the State. *See infra* at 28-31 (addressing those aspects). But the appointment of a Receiver by itself is not an order with which the State has to comply.

Br. 14-15. But they face an even greater difficulty here because the Receiver's preliminary plan is not a "court orde[r]." *See* 18 U.S.C. § 3626(a)(3)(A)(ii). Nor did it require that the State "comply" with anything.[9] *Id.*

Similarly, appellants fault the *Coleman* district court for failing to provide reasonable time for the State to comply with various 2006 orders directed at improving coordination of the Special Master's plans in *Coleman* with the Receiver's plans in *Plata*. Appellants characterize these orders as a "new remedial program." State Br. 21. Even if these rulings involved a remedial "program," they did not involve orders with which "the defendant" had to "comply," 18 U.S.C. § 3626(a)(3)(A)(ii), because they related only to coordination between court-appointed agents. *See, e.g.*, *Plata* D.E. 691. Thus, under the terms of the PLRA, these orders could not delay the decision to convene a three-judge court.

2. While a number of post-2005 orders from the single-judge district courts did require the State to "comply" with some directive, the PLRA did not require postponing the convening of a three-judge court because these orders were not the kind of

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[9] The *Plata* Receiver did not file a final Plan of Action until November 15, 2007, *Plata* D.E. 929, 930, *after* the three-judge court had properly been convened to address the issue of a capacity limit. Thus, that order does not qualify as a "previous" court order, as the PLRA requires. Appellants provide no support for concluding that "previous" means "subsequent." Furthermore, by the time the *Plata* single-judge court accepted the Plan, it had determined that the Plan by itself would be inadequate to remedy the violation fully. *See* JS1-App. 155a (reiterating that conclusion).

orders to which Sections § 3626(a)(3)(A)(i)-(ii) refer, given that the orders could not by themselves "remedy" the deprivation of constitutional rights. This is shown both by a facial examination of the orders and by district court factual findings that the orders could not remedy the violation.[10]

In contrast to the 2002 order in *Plata* and the 1995 order in *Coleman* – both of which ordered full compliance with constitutional standards and thus required giving the State "reasonable time" for compliance – the 2006 and 2007 orders binding on the State addressed only discrete aspects of the ongoing constitutional violation. For instance, as part of the order creating the Receivership – which, as previously explained, was not itself an order with which the State had to comply – the *Plata* court further ordered that "[p]ending development of a Plan of Action, the Receiver shall undertake immediate and/or short term measures designed *to improve* medical care and *begin the process of* restructuring and development of a constitutionally adequate medical health care delivery system." *Plata* D.E. 473 at 3:3-6 (emphasis added). To be sure, the court was required to determine whether the Receiver could remedy the violations before it convened a three-judge court or issued a crowding reduction remedy, and it did so, finding that the Receiver would be unable to cure the violations while the prisons remain overcrowded. Other orders issued by the single-judge district courts similarly could not have remedied the violation, even cumulatively, without a capacity limit order. *See, e.g., Coleman* D.E. 2200 at 1:25-26 (approving the Special Master's long-range bed plan).

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[10] The evaluation of whether a previous order may "remedy" the violation is one the single-judge court must make when it considers convening a three-judge court. First, the PLRA does not contemplate any distinction between partial relief and remedies outside the context of convening a three-judge panel. Therefore, most orders do not specify whether the court anticipates the order will "remedy" the violation, although it certainly may have so intended. Moreover, factual conditions often change, thus revealing past assessments regarding the effectiveness of remedial orders as inaccurate. Indeed, as appellants argue elsewhere, courts should tailor remedies to current conditions.

Accordingly, in their orders to convene a three-judge court, both district courts found that their recent orders could not remedy the underlying violations without an overcrowding reduction order. Those findings must be accepted unless "clearly erroneous." ***Amadeo v. Zant,*** 486 U.S. 214, 223 (1988).[11] In ***Plata,*** the district court found the record "clear that the Receiver will be unable to eliminate the constitutional deficiencies at issue in this case in a reasonable amount of time unless something is done to address the crowded conditions in California's prisons." JS1 App. 286a. Similarly, the district court in *Coleman* found "that the overcrowding crisis in the CDCR is preventing the delivery of constitutionally adequate mental health care to the plaintiff class."

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[11] The clear error standard would apply even if this Court were to treat the conditions of Section 3626(a)(3)(A) as jurisdictional. *See Correspondent Serv. Corp. v. First Equities Corp. of Fla.*, 338 F.3d 119, 123 (2d Cir. 2003) (Sotomayor, J.) (appellate courts considering jurisdictional questions "review a district court's factual findings for clear error and its legal conclusions *de novo*"); *see also Kanter v. Comm'r of Internal Revenue*, 590 F.3d 410, 424 (7th Cir. 2009) (same).

Id. at 304a. The three-judge court reiterated these findings two years later:

> While improvements have been and continue to be made, and the *Plata* and *Coleman* courts have continued their efforts during this three-judge court proceeding, it is clear that the Receiver and the Special Master cannot remedy the constitutional violations in the absence of a prisoner release order.

JS1 App. 166a. Thus, the single-judge courts each properly found that their more recent orders could provide only partial relief and would not themselves remedy the constitutional violations. Therefore, these orders did not trigger the PLRA's mandate that the State have additional time for compliance before a three-judge court could be properly convened.

Appellants' lengthy argument to the contrary misses the mark. Improvements in prison conditions preceding and following the convening of the three-judge court do not undermine the single-judge courts' findings that their more recent orders were incapable of bringing the state into constitutional compliance.[12]

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[12] Moreover, appellants misleadingly cite data regarding staffing levels in California's prisons. State Br. 38. Starting in 2009 and continuing to date, CDCR has been attempting to furlough all custodial staff for three days per month, thereby reducing staffing levels without those reductions being evident in the State's statistics. Additionally, CDCR has been running many "non-critical" positions vacant through a cost-saving "redirection" program, which further hides the actual level of staffing when citing only vacancy rates. Finally, California recently slashed its funding for prison operations and health care by hundreds of millions of dollars. These are, to say the least, *not* promising signs of improvement.

3. In any event, the PLRA does not contemplate that the procedural decision to convene a three-judge court – as opposed to the substantive decision of a three-judge court with respect to a PRO – should be subject to appellate review. Appellants argue that Section 3626(a)(3)(A) establishes jurisdictional conditions without which a three-judge court would be improperly convened and therefore lack jurisdiction to enter a PRO.[12] State Br. 24-25. This interpretation finds no support in the PLRA and would produce only protracted collateral appeals while adding little to the PLRA's substantive limitation on the scope of the courts' remedial powers.

The structure of the PLRA indicates that Congress protected state interests through the requirements of Section 3626(a)(3)(E)(ii). Before issuing any sort of PRO, a three-judge panel must find by clear and convincing evidence that "no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E)(ii). Thus, a three-judge court may not issue a PRO if any other form of relief could remedy the violation. In effect, this inquiry incorporates the requirements of Section 3626(a)(3)(A) and prevents a three-judge panel from acting prematurely because it forces the court to refrain from issuing a PRO when other avenues of relief may fix the violation. Here, the three-judge panel found, by clear and convincing evidence, that "no other relief" will remedy the violation of the Federal right. JS1-App. 168a; *id.* at 145a-168a.

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[12] The conditions in Section 3626(a)(3)(A) apply to the convening of a three-judge court because they are cross-referenced in Sections 3626(a)(3)(C) and (D), which specify when a three-judge court should be convened.

Appellants characterize Section 3626(a)(3)(A)'s requirements as jurisdictional. However, the fact that Congress used Section 3626(a)(3)(E)(ii) to prevent premature release orders suggests that Congress used Section 3626(a)(3)(A)'s requirements merely to avoid wasting limited district court resources by unnecessarily convening a three-judge court. This interpretation is consistent with Section 3626(a)(3)(B), which provides for prison release orders "if the requirements of *subparagraph (E)* have been met." 18 U.S.C. § 3626(a)(3)(B) (emphasis added). The PLRA does not contemplate any independent review of the single-judge court's determination to convene a three-judge court by either the three-judge court or an appellate court.

Moreover, appellants' interpretation would generate simultaneous and potentially conflicting appeals before this Court and the court of appeals. If a defendant were entitled to appeal the decision to convene a three-judge court, it would file such an appeal in the court of appeals and it could do so only after the three-judge panel has entered a final judgment. *See Coleman v. Schwarzenegger*, Nos. 07-16361, 07-16383, 2007 WL 2669591 (9th Cir. Sept. 11, 2007) (citing *Cohen v. Beneficial Indus. Loan Corp.*, 337 U.S. 541, 545-47 (1949)). By contrast, any appeal from the judgment of the three-judge court would come to this Court. 28 U.S.C. § 1253. Therefore, appellants' interpretation creates the real possibility of conflicting decisions. For instance, this Court could affirm the three-judge court's final order only to have the Ninth Circuit reject the convening of and underlying basis for the panel's "jurisdiction." There is no reason to interpret the PLRA to create simultaneous appeals and thus a potential for conflict. After a three-judge panel is convened, Section 3626(a)(3)(E) effectively subsumes the conditions in Section 3626(a)(3)(A).

Finally, the conditions in Section 3626(a)(3)(A) would not implicate the three-judge court's jurisdiction in any event. *See Jacobs v. Tawes*, 250 F.2d 611, 614 (4th Cir. 1957) (Parker, C.J.) ("The court of three judges is not a different court from the District Court, but is the District Court composed of two additional judges sitting with the single District Judge before whom the application for injunction has been made."); Note, *Reviewing the Grant of a Three-Judge Court*, 69 Colum. L. Rev. 146, 154 (1969) (describing this Court's treatment of conditions for convening a three-judge court as nonjurisdictional).

C. Attacks On The Composition Of The Three-Judge Court Are Untimely And Meritless.

Neither appellants nor appellant-intervenors raised any objections below to the composition of the three-judge court in this case. Nevertheless, before this Court, they and their *amici* intimate that there is something irregular about the assignment of Judges Karlton and Henderson to the three-judge court. Thus, appellants argue that if this Court were to decide that a three-judge court should have been convened in only one of the two consolidated cases, then its remand order should direct that a new three-judge court be convened and that the Chief Judge of the Ninth Circuit should "'designate two other judges' as [28 U.S.C.] § 2284 commands." State Br. 25-26 n.8. The import of their argument is that such a newly convened three-judge court start from scratch in considering whether to address the continued overcrowding and ongoing constitutional violations in the California system.

To begin with, appellants have waived any objection to the membership of the three-judge court and offer no excuse for their waiver. *Hicks v. Miranda*, 422 U.S. 332, 338 n.5 (1975) (objections to membership of three-judge courts cannot be initiated on appeal). In any event, Chief Judge Schroeder fully complied with the requirements of Section 2284. She in fact did "designate two other judges" in each of the cases before her. For *Coleman*, where Judge Karlton was the initiating judge, she designated Judges Henderson and Reinhardt. For *Plata*, where Judge Henderson was the initiating judge, she designated Judges Karlton and Reinhardt. Nothing in the statute prevents such cross-designation.

Indeed, the regular practice of federal courts in analogous circumstances supports such consolidation in the interests of consistency and judicial economy. For example, in *Mahan v. Howell*, 410 U.S. 315 (1973), the Supreme Court reviewed a decision of a four-judge district court which had ruled on three consolidated cases. The Court never so much as hinted that there was any problem with the district court's composition. *Id.* at 318; *see also Federal Election Comm'n v. National Conservative Political Action Comm.*, 470 U.S. 480, 483 (1985) (referencing the consolidation of cases to the same three-judge district court where the FEC brought "separate action[s] against the same defendants seeking identical declaratory relief").

II. The Three-Judge Court Correctly Found That Overcrowding Is The Primary Cause Of The State's Ongoing Constitutional Violations And That No Other Relief Would Remedy Those Violations.

The PLRA authorized the three-judge court to issue a capacity limit order if it found by "clear and convincing" evidence that crowding was the "primary cause" of California's failure to provide constitutionally adequate health care and that "no other relief" would remedy the State's Eighth Amendment violations. *See* 18 U.S.C. § 3626(a)(3)(E). Appellants offer two arguments as to why the district court erred in finding that overcrowding was "the primary cause" of the constitutional violation. First, they contend the word "primary" requires plaintiffs to show "an elevated level of 'but for' causation." State Br. 31. Second, they suggest overcrowding is not the primary cause of the State's constitutional violation, because while remedying overcrowding might be necessary to eliminate the violation, it is not sufficient to do so. State Br. 33. These arguments find no support in the text or purposes of the PLRA, and defy the commonsense understanding of causation. Because overcrowding is the principal obstacle to achieving constitutionally adequate health care in the California prison system, it is "the primary cause" of the Eighth Amendment violation. Since "no other relief" could produce constitutional compliance as long as overcrowding persists, the three-judge court correctly ordered a PRO.

A. The Three-Judge Court Properly Understood That The "Biggest Inhibiting Factor" To Fixing A Constitutional Violation Is "The Primary Cause" Of That Violation.

1. Courts apply "ordinary meaning" when, as is true for the words "primary cause" in the PLRA, a statute provides no definition for a particular term. *See Hamilton v. Lanning*, 130 S. Ct. 2464, 2471 (2010) (citing *Asgrow Seed Co. v. Winterboer,* 513 U.S. 179, 187 (1995)). Accordingly, the three-judge court properly interpreted the term "primary cause" by looking to its ordinary usage.

The three-judge court employed a standard dictionary definition of the meaning of "primary." *See* JS1-App. 78a (defining "primary" as "first or highest in rank or importance; chief; principal") (citing *Random House Webster's Unabridged Dictionary* 1537 (2d ed. 1998)). *See also* 7 *Oxford English Dictionary* 472 (2d ed. 1989) (defining "primary" as "[o]f the highest rank or importance; that claims the first consideration; principal, chief"). In light of that definition, the three-judge court correctly understood that the question before it was whether, at this point in time, the most important impediment to fixing the unconstitutional conditions in the California prison system was overcrowding. *See* 18 U.S.C. § 3626(a)(3)(E)(i) (describing the three-judge-court's adjudication in the present tense; whether "crowding *is* the primary cause of the violation") (emphasis added). Certainly, the PLRA does not require a three-judge court to decide that question in the abstract or for all time. Instead, it directs the court to adjudicate that question based on the evidence before it, and in a context where "no other relief" can provide a remedy. 18 U.S.C § 3626(a)(3)(E). In short, as the three-judge court understood here, if overcrowding is the "biggest inhibiting factor" to providing constitutionally adequate health care within California's prisons under current conditions, then it is the "primary cause." JS1-App. 82a.

There is no indication that Congress intended to depart from this ordinary meaning when it used "primary cause" in the PLRA. The term "primary cause" is not a statutory or legal term of art. As the State itself admits, Congress has used "primary cause" rarely, State Br. 30, and certainly not with the requisite frequency to establish a special statutory meaning. *Cf. Dir., Office of Workers' Comp. Programs, Dep't of Labor v. Newport News Shipbuilding & Dry Dock Co.*, 514 U.S. 122, 126 (1995) (noting that the repeated and "long use" of a phrase in multiple statutes can create a "term of art"). Nor do appellants provide any reason to believe that Congress purposefully chose that term in order to adopt idiosyncratic legal meanings plucked from a more than one-hundred-year-old admiralty case, or a railroad injury decision not cited by any federal court in the last half-century. *See* State Br. 31 (citing *The G.R. Booth*, 171 U.S. 450 (1898); *Rocco v. Lehigh Valley R.R.*, 288 U.S. 275 (1933)).

To the contrary, what evidence there is suggests that when Congress uses the term "primary cause" it does so in contexts other than statutory requirements, such as legislative findings or committee reports, and it uses those words in their ordinary sense to refer simply to a particularly fundamental factor (or factors) explaining an observed condition. *See, e.g.*, Pub. L. No. 110-180, § 2(5)(a)-(b), 121 Stat. 2559, 2560 (2008) (finding that both a lack of updated criminal records and a lack of firearm restriction records were the "primary cause," in the singular, of delay in background checks); Pub. L. No. 111-22, § 1002(a)(1), 123 Stat. 1663, 1664 (2009) (finding that both "a lack of affordable housing and limited scale of housing assistance programs are the primary causes of homelessness"). Moreover, around the time Congress enacted the PLRA, it also found in other contexts that a factor can be a "primary cause" even if eliminating that factor would not by itself cure the problem. *See, e.g.*, S. Rep. No. 105-149 (1997) (finding that even though habitat degradation also "played a role," overfishing "was the primary cause of the decrease in striped bass"); S. Rep. No. 102-263 (1992) (finding that although "heart disease is the primary cause of total and permanent disability," "lung diseases are the fastest growing cause of total and permanent disability"). Thus, when the three-judge court construed the term "primary cause" in its ordinary sense, it interpreted the term consistent with typical congressional usage.

2. Neither of the two alternative definitions for "primary cause" that the State proposes withstand scrutiny.

a. Had Congress intended "primary cause" to mean an "elevated level of but for causation," or "proximate cause," as appellants urge, State Br. 31, it would have used language to that effect. When Congress wants to require "proximate cause," it knows how to do so. Several statutes enacted contemporaneously with the PLRA used precisely that term. *See, e.g.*, Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Pub. L. No. 104-204, § 422, 110 Stat 2874, 2926 (1996) (formerly codified at 38 U.S.C. § 1151(a)(1)); Housing and Community Development Act of 1987, Pub. L. No. 100-242, § 147, 101 Stat. 1815 (1988) (codified at 42 U.S.C. § 1437f(t)(1)(A)). But Congress did not require "proximate cause" in the PLRA, and this Court should not rewrite the statute to do so.[14]

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[14] Nor is there reason to believe that Congress drew from a few scattered court of appeals decisions from widely varied areas of law that contain the words "primary cause" but do not construe the term as a statutory phrase. *See* State Br. 31 (citing *Metro. Pittsburgh Crusade for Voters* v. *City of Pittsburgh*, 964 F.2d 244, 251 (3d Cir. 1992); *Hawkins* v. *Dir., Office of Workers Comp. Programs, Dep't of Labor*, 907 F.2d 697, 705 n.12 (7th Cir. 1990); *Borras* v. *Sea-Land Serv., Inc.*, 586 F.2d 881, 885-86 (1st Cir. 1978)).

In any event, the decisions cited by appellants do nothing to undermine the approach taken by the three-judge court here. The three-judge court never conflated "primary cause" with "simple contributing cause," *Hawkins*, 907 F.2d at 705; "contributing factor," *Borras*, 586 F.2d at 885-86, or "material contributing factor," *Pittsburgh Crusade*, 964 F.2d at 251. It always understood that the PLRA required it to ask whether crowding was a principal or fundamental or highly important explanation for the constitutional violation.

Moreover, none of appellants' citations provide support for their assertion that a primary cause "must encompass" the concept of "proximate cause." State Br. 31. In *Pittsburgh Crusade*, the Third Circuit was addressing the question of what counts as a "material contributing factor" for purposes of applying a fees statute. In the course of explaining whether a "material contributing factor" is less than "but for" or "proximate" cause, the court pointed to a decision in another case that had explained that a "material contributing factor"

Appellants' contention that Congress intended to heighten a "pre-existing" judicial causation requirement is also misplaced. *See* State Br. 32. Rather, Congress crafted Section 3626(a)(3) as a disapproving response to judicial decrees where courts had ordered the release of prison inmates without first finding that overcrowding had caused any constitutional violation at all. *See, e.g.*, 141 Cong. Rec. S14316 (daily ed. Sept. 26, 1995) (statement of Sen. Spencer Abraham) (criticizing a district court order on these grounds); *Taking Back Our Streets Act of 1995: Hearing Before the Subcommittee on Crime of the Senate Committee on the Judiciary*, S. Hrg. 104-99, 104th Cong. (Jan. 19, 1995) (statement of Philadelphia District Attorney Lynn Abraham) (same). Given this preoccupation with federal courts not making *any* causation findings, it is implausible that Congress legislated against the background of some unstated but preexisting causation requirement.

Even if it had been aware of the few cases appellants cite for this proposition, Congress could not have gleaned from them a settled causation test for issuing PROs. Indeed, two of these cases do not even involve PROs, but instead address a wholly

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test was also less exacting than a requirement that the plaintiff show that the litigation was "the sole or even the primary cause." But the Third Circuit offered no comparison between "but for" and "proximate" cause on the one hand, and the "sole" or even "primary" cause on the other. 964 F.2d at 251. In *Hawkins*, a black lung disability benefits case, the Seventh Circuit introduced the term "primary cause" as a non-technical contrast to "'simple' contributory cause," and used the term interchangeably with "substantial contributing cause." 907 F.2d at 705.

different legal question: prison officials' liability for inmate-on-inmate harms. *See* State Br. 32 (citing ***Abrams v. Hunter***, 910 F. Supp. 620, 621 (M.D. Fla. 1995) ***aff'd***, 100 F.3d 971 (11th Cir. 1996); ***Marsh v. Barry***, 824 F.2d 1139, 1140 (D.C. Cir. 1987)).

b. This Court should also reject appellants' assertion that a factor cannot be "the primary cause" within the meaning of the PLRA unless addressing it is not only necessary, but also sufficient, to cure the constitutional violation. State Br. 30. Appellants suggest that "[i]f overcrowding is the primary cause, then eliminating overcrowding should undo all or virtually all of the constitutional harm." *Id.* Appellants would thereby effectively rewrite the PLRA to require proof that overcrowding is the "sole," rather than simply the "primary," cause of the violation. This Court should reject such a construction, which does not track reality and creates potential constitutional difficulties.

In reality, most complex problems – and certainly unconstitutional prison health care systems – stem from multiple causes that must be addressed before the problem can be fully solved.[15] But even complex problems have a primary cause that must be tackled first. In other words, as long as that "primary cause" persists, not only will solutions to other causes fail to remedy the problem completely, but those solutions will themselves be undermined.

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[15] Indeed, even proximate causation recognizes multiple sufficient causes such that even if one catalyst were prevented, the same outcome would nevertheless occur. Restatement (Third) of Torts: Phys. & Emot. Harm § 27 (2010).

Appellants' suggestion to the contrary threatens absurd results unintended by Congress. Suppose a jurisdiction were to deny some citizens the right to vote because a budget crisis prevented it from operating sufficient polling places and because its antiquated polling machines were subject to mechanical failures. No one would doubt that the budget crisis was the primary cause of the constitutional violation. But under appellants' definition, the budget crisis could not be the "primary cause" because even once the board of elections obtains funds to reopen its polling locations, it will still continue to deny some voters their rights until it also updates its voting equipment. Appellants' reading would lead to similarly absurd results in the context of the PLRA, barring courts from addressing problems that unquestionably pose the biggest obstacles to constitutional relief.

Appellants' interpretation would also raise serious constitutional problems by creating insoluble circularity. Their interpretation presupposes that a court faced with a situation where crowding and some other factor each contribute to the unconstitutional situation can separately address the other factor first, at which point crowding will be the sole remaining cause and thus amenable to a PRO. But it is possible that there will be situations where the other factor *cannot* be addressed absent a response to the crowding. Suppose that a state were to stipulate that (1) as long as its facilities remain overcrowded, conditions within the system would continue to violate the Eighth Amendment, but were to claim (2) that if it were to reduce its population relative to capacity, it could provide constitutionally adequate care by converting five former dormitories into clinics and staffing them. Even then, under appellants' definition, overcrowding would not be "the primary cause" because one additional step is necessary to remedy the violation. Thus, in a case where all agreed that constitutional compliance could not be achieved without a reduction, the State's construction of the PLRA would mean that federal courts would be precluded from ordering relief.

In other words, under appellants' strained interpretation, the PLRA would sometimes bar constitutionally necessary PRO orders altogether, rather than merely make them a "remedy of last resort," as Congress intended. H.R. Rep. No. 104-21, at 25 (1995). To avoid such constitutional insolubility, the Act must be construed to permit courts to order a PRO in situations where, as here, such an order is truly necessary to prevent unabated constitutional violations.

B. Clear and Convincing Evidence Showed That Overcrowding Is The "Primary Cause" Of The Eighth Amendment Violations In These Cases And That "No Other Relief" Will Remedy These Violations.

The three-judge court's order setting a 137.5% capacity limitation on California's prison system rests on detailed factfinding following two years of extensive discovery, the admission of several hundred exhibits into evidence, and a fourteen-day trial. The court heard or received testimony from more than fifty witnesses, including four current or former state-level prison administrators, numerous medical and mental health care experts, and frontline providers within the California system. JS1 App. 70a, 81a. This evidence showed to a clear and convincing—indeed, an "overwhelming," *id.* at 140a—degree that overcrowding was the primary cause of ongoing unconstitutional conditions in California prisons, and that no other relief would remedy these violations. *Id.* at 82a, 145a.

This Court should affirm the three-judge court's factual findings unless it is "left with the definite and firm conviction that a mistake has been committed." *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948). Notwithstanding appellants' attempt to draw the Court into *de novo* review by quibbling over what the word "primary" means, the question of whether overcrowding is the "primary" (as opposed to a merely "contributory," App. Brief 32) cause of California's violations is essentially factual. *See, e.g., Easley v. Cromartie*, 532 U.S. 234, 242 (2001) (applying clear error review to a three-judge court's evidentiary determination that race was the predominant motivation for redistricting). So too is the question whether "no other relief" would remedy the constitutional violations, in that answering that question involves a prediction about a factual state of the world. Thus, this Court should defer to the district court's findings on both questions unless those findings are clearly erroneous.

Here, there can be no real reason—let alone a definite and firm conviction—to believe that the three-judge court erroneously found (1) that overcrowding is the "primary cause" of California's unconstitutional prison conditions, and (2) that "no other relief" than a §3626(a)(3) order could rectify its violations.

1. Appellants make no attempt to dispute the extensive predicate factual findings that the three-judge court made to support its ultimate finding that overcrowding is at the crux of multiple deficiencies "central to the ongoing violation of California inmates' constitutional right to adequate medical and mental health care." JS1-App. 85a. The court found – and the State does not contest – that California's maintenance of a prison population almost double the design capacity causes the following: (a) unconstitutionally limited access to care; (b) extreme departures in the standard of care; (c) serious delays in the provision of care; and (d) the unnecessary infliction of infectious diseases. *Id.* 85a-118a. At trial, these findings were supported by "clear and convincing" evidence, and defendants presented no credible evidence to the contrary. *Id.* at 141a.

a. *Inadequate access to care.* Because the prison population so exceeds design capacity, California prisons simply lack the space to deliver constitutionally minimal medical and mental health care. The court heard extensive evidence showing a severe shortage of clinical space throughout the system, *id.* at 92a-95a, and found particularly persuasive the *Plata* Receiver's report that "investments in health care facilities have significantly lagged behind growing inmate populations, so much so that available clinical space is less than half of what is necessary for daily operations." *Id.* at 93a.

The three-judge court also found that space constraints from overcrowding caused a severe shortage of designated beds for inmates in need of mental health services. *Id.* at 97a. As the court noted, "[i]t is not simply the beds themselves that the state does not possess, but the *space in which to place them.*" *Id.* (emphasis added). It further found that "new mental health beds cannot be added quickly enough" because "overcrowding has led to a significant, unaddressed demand for mental health services that only becomes more acute over time." *Id.* at 99a. As several expert reports showed, when "inmates are denied necessary mental health placements" because of bed shortages, they "'end[] up in mental health conditions more acute than necessary. *Id.* This creates "a cycle of sicker people being admitted, with greater resources necessary to treat them, which then creates even further backlog in an already overwhelmed system." *Id.* (citing the report of a mental health expert).

The three-judge court also found that overcrowding is the principal barrier to health care access at reception centers for inmates who have yet to be assigned to a CDCR prison. Again, overcrowding erects obstacles to care through a destructive feedback loop: capacity overload at the main prisons results in inmates being held for unusually long periods at the reception centers. *Id.* at 86a. As a result, some reception centers are operating at nearly 300% of design capacity, and must rely on clinical facilities not equipped to handle long-term treatment of chronic conditions even at 100% of capacity. "This severe crowding . . . makes it impossible to provide medical and mental health services to inmates" who are housed without adequate care for extended periods of time. *Id.*

At the same time, the shortage of clinical space "makes it impossible" for California prisons to accommodate additional staff. *Id.* at 106a-107a. The three-judge court cited evidence from a number of chief medical officers that the prisons "would not have sufficient space for clinical staff if all of the clinical positions currently budgeted were filled, let alone if new positions were created and filled." *Id.* (internal citations omitted). Without sufficient staff, California prisons cannot provide sufficient health care, and "[e]very day" must "make the difficult decision" to flout a federal judicial order in one of the many prison conditions cases that have been adjudicated against the California system. *Id.* at 104a-105a (citing the *Plata* Receiver's 2007 Report).

In addition to finding deficient medical staffing, the three-judge panel found that correctional staff cannot fully perform their duties to facilitate health care because of overcrowded conditions. Not only are there insufficient custodial staff, but overcrowding prevents existing staff from identifying medical needs and responding in a timely fashion. *Id.* at 111a-112a.

b. *Extreme departures from the standard of care.* Even when inmates are able to access care, the court found that overcrowding frequently results in grossly inadequate care. Extreme departures from the standard of care begin at intake facilities, where space shortages prevent prisons from properly screening newly admitted inmates. *Id.* at 88a (citing expert testimony describing intake rooms so small that it is "very difficult if not impossible to perform an actual physical examination"). As a result, inmates' health conditions may be misdiagnosed, or missed entirely. *Id.* at 89a. Experts also testified that overcrowding "makes it impossible" for California's prisons to manage medical records, which further compromises care. *Id.* at 121a; *see also id.* at 119a-121a.

In addition, the court found that overcrowding leads to inadequate medication delivery. *Id.* at 112a. Numerous witnesses testified that because of overcrowding, "there are more patients requiring medications than the prison has the resources or staffing to address." *Id.* As a result, correctional officers have witnessed prisoners receiving their medication late, not at all, or may even receive the wrong medication. *Id.* (citing 4 Tr. 670-73 (testimony of Correctional Officer Deborah Rowlett) (describing the improper administration of medicine caused by overcrowding)). Though more staffing would obviously reduce the chance of errors and alleviate burdens on existing staff, the court expressly rejected the idea that more clinical staff could fit into the existing space. JS1-App. 107a.

c. *Serious delays in the provision of care.* On top of these problems, the three-judge court also found that overcrowding "engenders a state of perpetual crisis" that seriously delays the provision of care and contributes to an "unacceptably high" number of preventable deaths. JS1-App. 116a, 123a. In particular, overcrowding in California's prisons substantially increases the use of lockdowns to control prison populations, thus delaying the provision of medical care. *Id.* at 116a. When a prison is in lockdown, correctional officers must escort prisoners individually to and from clinic areas. *Id.* at 117a. Thus, delays in access to care are particularly "acute" during lockdowns because prisons are not sufficiently staffed to safely deliver care in this manner. *Id.* at 116a-117a.

d. *Infectious diseases.* Finally, the three-judge court credited the testimony of multiple experts regarding the relationship between crowding and disease, such as staph infections and tuberculosis. For example, Scott Kernan, then the Chief Deputy Secretary of the Division of Adult Institutions for the CDCR, testified that overcrowded housing conditions led directly to the increased spread of infectious diseases, JS1-App. 102a, that further overloaded the already constitutionally inadequate health care system. The three-judge court thus found that, "[u]ntil CDCR reduces its population, it will remain highly vulnerable to outbreaks of communicable diseases." *Id.*

2. After concluding that overcrowding is the primary cause of the ongoing health care violation in California's prisons, the three-judge panel correctly found that no relief other than a capacity limitation would remedy that violation. The court relied on multiple experts' conclusions that "the only avenue for building a constitutional health care delivery system is to reduce the demand on the system by lowering the number of patients it serves" within the existing facilities. JS1-App. 164a (citing Dr. Ronald Shansky); *see also, e.g., id.* (citing defendant-intervenors' expert Dr. David Bennett agreeing that "the necessary constitutional medical and mental health care services can't be provided with today's overcrowding").

Because overcrowding is clearly the first-order cause of the problems described above, every other feature of a comprehensive remedy for the unconstitutional conditions "depend[s] upon a reduction in prison overcrowding for [its] success."

JS1-App. 168a. After thoroughly canvassing the evidence, the three-judge court found that limiting capacity is "the only way to create an environment in which other reform efforts, including strengthening medical management, hiring additional medical and custody staffing, and improving medical records and tracking systems, can take root in the foreseeable future." *Id.* Because the clear and convincing evidence supported this conclusion, the three-judge court properly found that "no other relief" would suffice to solve the Constitutional violation. *Id.* at 145a.

3. Appellants suggest that the three-judge court's findings are tainted by reliance on stale evidence. That criticism is incorrect. The three-judge court based its findings on evidence of the State's ongoing failure to remedy admitted Eighth Amendment violations.

That those violations persisted up through the time the three-judge court was convened cannot be seriously disputed. In their separate orders granting appellee's motions to convene the three-judge panel, the *Plata* and *Coleman* single-judge courts both found – ***without objection from appellants*** – that the constitutional violations were ongoing. JS1-App. 77a.

The three-judge court fully understood the current conditions in California's prisons because both sides presented up-to-date evidence throughout the three-judge court proceedings.[16] Appellants' contention to the contrary misstates the record. As the *Plata* appellees' brief describes in detail, *Plata* App. Br. 37, the State's own experts testified at length about current conditions, having toured the prisons only a few weeks before trial. The State also introduced current data on prison health and staffing levels, as well as detailed reports on current conditions from the *Coleman* Special Master and *Plata* Receiver. JS1-App. 77a. Thus, although the three-judge court properly adhered to its remedial role in refusing to re-adjudicate the predicate constitutional violations already found by the single-judge district courts, it clearly considered the current state of the violations in deciding that overcrowding

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[16] Appellants and their *amici* contend at various points that the three-judge court should have re-adjudicated whether the underlying Eighth Amendment violations were continuing. *See,*

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e.g., State Br. 27; CJLR Br. 6 (arguing that "the three-judge District Court had jurisdiction over the whole case").

These arguments are misplaced. Unlike other statutory provisions for convening three-judge panels, the PLRA grants the three-judge court authority only to enter a prisoner release order. *See* Comment, *Coleman v. Schwarzenegger*, 123 Harv. L. Rev. 752, 757 (2010) ("Although the statute does not explicitly require that three-judge courts limit themselves to the consideration of prisoner release orders, the statute's separation of prisoner release orders from other remedial stages implies such a limitation.").

This Court also has articulated strong reasons why a limited role for three-judge courts promotes judicial economy. *See Swift & Co. v. Wickham*, 382 U.S. 111, 124 (1965) (placing additional issues before a three-judge court "'not only expands this Court's obligatory jurisdiction but contradicts the dominant principle of having this Court review decisions only after they have gone through two judicial sieves.'" (quoting *Fla. Lime & Avocado Growers, Inc. v. Jacobsen*, 362 U.S. 73, 92-93 (1960) (Frankfurter, J., dissenting))).

was the "primary cause" and that "no other relief" would suffice to remedy them.[17]

III. The Three-Judge Court Properly Imposed The 137.5% Capacity Limitation.

Once the three-judge court found that overcrowding in California's prisons was "the primary cause" of ongoing constitutional violations that could not be remedied by other forms of relief, it was required to respond to the overcrowding. *See* 18 U.S.C. § 3626(a)(3)(E) (listing the circumstances under which prisoner release orders can be entered). The court responded by entering an order determining the level of design capacity that could be maintained consistent with the State's constitutional obligations. Correctional experts offered the court an array of possibilities, ranging from 90% to 145% of design capacity. JS1-App. 178a-181a. The former

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[17] Even if this Court were to determine that it was within the power of the three-judge court to reconsider decisions of the single-judge district courts, the three-judge court would not be compelled to do so and could instead, "pass [any] claim back to the single judge." *Hagans v. Lavine*, 415 U.S. 528, 544 (1974). *Amicus curiae* CJLF's citation of a sentencing decision is inapposite. *See* CJLF Br. 10. A judge's failure to recognize discretion in sentencing affects a defendant's substantive rights. In this case, any decision by the three-judge panel declining to exercise such discretion deprives the State of nothing since the single-judge courts retained their jurisdiction over all other matters except the issuance of a PRO.

Finally, CJLF plainly misinterprets § 2284(b)(3), which states only that a member of a three-judge court may review actions of single-judge courts in his or her capacity as a member of the panel. *See Eastern States Petroleum Corp. v. Rogers*, 265 F.2d 593, 597 (D.C. Cir. 1959) ("the expression 'single judge' [in § 2284] refers to a single judge of a three-judge court").

Secretary of the CDCR, Jeanne Woodford, concluded, based on her own experience managing California's prison system, that a 5% vacancy rate is necessary to providing adequate care. *Id.* at 178a. Joseph Lehman, the former head of corrections in Pennsylvania, Washington, and Maine, explained that since the health care facilities at California's prisons were not designed to provide care for more than the number of inmates at 100% design capacity, they would not be able to provide required health care services much beyond that level. *Id.* at 177a. The ***Coleman*** and ***Plata*** appellees presented evidence that constitutional compliance required a population of no more than 130% of capacity. *Id.* at 179a-180a. Finally, the State's Corrections Independent Review Panel (CIRP) concluded that 145% was the operable limit for California's prisons. *Id.* at 181a.

By contrast, appellants declined to provide any number at all (or any constitutionally adequate alternative to setting a number). *Id.* at 175a. Nor did they offer any guidance as to how the three-judge court might independently derive a capacity limit.

The three-judge court weighed the evidence before it and adopted a capacity limitation number near the top of the range offered to it, selecting a percentage equidistant from the figure proposed by the CIRP and the figure proposed by the plaintiffs. *Id.* at 184a. The three-judge court carefully considered the bases for the various proposals. For example, the CIRP's 145% figure rested on the overall functioning of the prison system without regard to the attainment of constitutionally adequate medical and mental-health services. *Id.* at 182a. Thus, the three-judge court concluded that a downward adjustment would be appropriate given that the only question pending before it was what level of capacity would be necessary to remedy the constitutional violations with respect to health care. *Id.* (citing Dr. Pablo Stewart for the proposition that 145% represented the maximum functional capacity without regard to ensuring constitutionally adequate care).

To be sure, the three-judge court had to exercise some judgment in selecting the precise capacity limit. But it was clearly appropriate for it to impose *some* numerical restriction. The number it set was narrowly tailored to the constitutional violation given the expert testimony upon which it relied, and therefore satisfies the PLRA's nexus requirement.

This capacity cap was narrowly tailored to cure the constitutional violations because any alternative mechanism for achieving constitutional compliance would actually be far more intrusive on the State's control over its prison system. Specifically, the 137.5% capacity order avoided the need for federal judges to make more intrusive decisions, such as orders transferring individual prisoners to particular facilities, determining the custody conditions for individual inmates, or ordering the actual release of specific prisoners.

The 137.5% capacity order, by contrast, leaves control over the day-to-day management of the prison system to the State. The State retains discretion to determine whether to achieve compliance by reducing sentences, diverting technical parole violators to noncustodial settings, increasing good time credits, building more prisons to increase the overall capacity as to which the 137.5% figure applies, or adopting other mechanisms that will have similar effects.[18]

A. In Setting The 137.5% Capacity Limit, The Three-Judge Court Gave The Appropriate Weight To Public Safety Concerns.

As Peace Officers of the State of California, the members of CCPOA are first and foremost concerned with law enforcement and public safety. Correctional officers confront daily the sobering realities of California's overcrowded prisons and the dangers they pose. CCPOA would not have taken the extraordinary step of intervening in this litigation if it did not recognize the real threat to the public and correctional officers caused by overcrowding.

Even the Governor has acknowledged that reductions in the prison population are necessary to address "substantial risk to the health and safety of CDCR staff [and] inmates." Plaintiffs' Tr. Exh. 1 at 2. It is at best hypocritical for the State to argue before this Court that the three-judge court inadequately considered public safety interests while asserting elsewhere that similar reductions of tens of thousands of inmates are necessary to protecting public safety. *Id.*; *see also Plata* D.E. 2258.

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[18] Even within this 137.5% capacity limit, the State may be required to initiate other policy changes to achieve constitutional compliance. (That is, the capacity cap is only one component of providing constitutionally adequate care.) In particular, current (and in some cases, enhanced) levels of correctional staffing will be required to ensure that even a less-overcrowded system can provide sufficient security and medical assistance to inmates. While the three-judge court found additional staffing alone could not resolve the constitutional deficiencies, it found that adequate staff are required to provide sufficient monitoring and "deliver[y]" of "inmates for necessary care." JS1-App. 112a.

In the course of crafting its capacity order the three-judge court heard nearly ten days of witness testimony and reviewed hundreds of exhibits specifically on the issue of public safety. JS1-App. 185a. In assessing this evidence, the court looked to evidence generated completely independent of this litigation, such as state reports examining different means for population reduction. *Id.* After considering all of this evidence, the court found that its capacity limit order would have "no adverse effect" on public safety. *Id.* at 234a. It further found that even if it were in error about there being no adverse effect, any such effect "would be small." *Id.* This conclusion was supported by the evidence, and the State has provided no credible evidence to undermine it.

First, while the State continues to claim that a reduction of the size required by the capacity limit order cannot be accomplished without adversely impacting public safety, this assertion is undermined by the fact that the State itself has separately offered numerous proposals to achieve similar reductions even without a court order. *Id.* at 197a (discussing the Governor's proposed expansion of good time credits); *id.* at 209a (discussing the proposal of the Governor's Rehabilitation Strike Team to divert technical parole violators); *id.* at 219a (discussing the Governor's proposal to adjust the threshold value at which property crimes constitute felonies). The three-judge court properly discounted the State's assertions in light of this contradiction and credited evidence that a variety of these reforms could be achieved without an adverse impact on public safety. *Id.* at 185a-254a.

More fundamentally, as discussed above, the prison capacity limit imposes no absolute cap on the number of inmates that California may incarcerate. The State always retains the option of increasing the denominator (capacity) in order to avoid decreasing the numerator (prisoners).

The three-judge court recognized that criminal justice and public safety are central concerns of the State, and it therefore deferred to the State's expertise as much as possible. In crafting an order that left the implementation decisions to the State, the three-judge court avoided the need to parse through each of the State's proposed reduction methods to assess the public safety effects. Instead, it left to the State the task of reaching the population limit in the way most consistent with protecting public safety and with California's priorities.

To support its claim that a capacity limit will adversely impact public safety, the State cites its own assertion in the version of its plan ultimately accepted by the court that it could not accomplish the goals of that plan without compromising public safety. State Br. 54. But such an unsupported assertion cannot be sufficient to preclude a PRO. If it were, then it is difficult to conceive of any instance where one could be authorized over a state's objection. Given that Congress explicitly provides for PROs within the PLRA, this Court should not embrace an interpretation of the Act which gives states veto power over congressionally-authorized remedies.

B. Federal Law Provides Sufficient Avenues For Obtaining Modifications Of The 137.5% Capacity Cap If Changed Circumstance So Require.

Appellants and their *amici* have argued that this Court should determine whether the capacity limit remains appropriate today in light of purported developments occurring since it was entered. CCPOA has already explained why, under the PLRA, neither the three-judge court nor this Court should revisit the existence of an ongoing constitutional violation. But even if recent developments warranted revisiting the details of the order in this case, federal law provides an adequate path for appellants to seek such relief.

As an initial matter, Fed. R. Civ. P. 60(b)(5) sets out the general mechanism for seeking relief from an injunction such as a PRO. The PLRA expressly contemplates the availability of Rule 60(b)(5) relief. *See* 18 U.S.C. § 3626(b)(4). Moreover, the PLRA additionally provides separate and more expansive authorization for periodic review of existing injunctions. *See id.* § 3626(b)(1). Those mechanisms – rather than plenary review by this Court, including evaluation of new evidence in the first instance – are what Congress intended as the appropriate avenues to seek revisions to a PRO, if such revisions were required by changed circumstances. Moreover, once the State has remedied the Eighth Amendment violations at the core of this case, it may then move for complete termination of injunctive relief under either of these avenues.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be affirmed.

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REPLY
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GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

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CONSOLIDATED REPLY BRIEF

We begin by stating what this appeal is not about.

It is not about the undesirable and negative effects of crowding on prison staff and the general prison population, the complex public policy issues implicated by the State's attempts to address crowding, or the actions necessary to bring medical and mental health care in California's prisons to levels that comport with the best professional practices. Compare, *e.g.*, *Coleman* Br. 7, 29, 60; *Plata* Br. 5; Br. of *Amici* Corrections & Law Enforcement Personnel 6-8. The State aspires to reduce crowding and to provide medical and mental health care that meets or exceeds professional standards. But it is the Eighth Amendment that sets the standards applicable here. The issue is whether prison crowding in California is the "primary cause" of specific alleged Eighth Amendment violations in medical and mental health care, and whether no relief other than a prisoner release order will remedy those alleged violations. The three-judge district court, however, issued an order for release of 38,000-46,000 prisoners based on standards that exceed the Eighth Amendment's requirements. See Opening Br. 42-49; *Rhodes* v. *Chapman*, 452 U.S. 337, 347-51 & nn.15-16 (1981); compare, *e.g.*, Br. of *Amici* American Public Health Association et al. 7-18.

This appeal also is not about what former officials did or failed to do to address prison medical and mental health care, or the repercussions those decisions had for inmates in the past. The State's former deficiencies do not negate the State's current compliance with extensive injunctive relief, its continuing progress toward remedying any alleged Eighth Amendment violations, and the likelihood that the significant injunctive relief already in force will succeed. Compare, *e.g.*, *Plata* Br. 48; *Coleman* Br. 3-4. Appellees' entitlement to a prisoner release order, like any injunction, must arise from current necessity, not from the desire to punish past wrongs. As Justice Jackson explained for this Court: "The sole function of an action for injunction is to forestall future violations. It is ... unrelated to punishment or reparations for those past .... This established, it adds nothing that the calendar of years gone by might have been filled with transgressions." *United States* v. *Or. State Med. Soc'y*, 343 U.S. 326, 333 (1952).

I. THIS COURT SHOULD REVERSE THE JUDGMENT BECAUSE THE THREE-JUDGE COURT WAS PREMATURELY CONVENED.

A. This Court Has Power To Review The Three-Judge Court's Authority To Order Prisoner Release.

The parties agree that this Court has exclusive jurisdiction to review a three-judge court's prisoner release order. In the Opening Brief (at 24), the State demonstrated that once vested with such appellate jurisdiction, this Court also has the power to decide whether the three-judge court had authority to enter the underlying order. Appellees' contrary arguments are without merit.

1. Appellees chiefly attack the State's reliance on *Gully* v. *Interstate Natural Gas Co.*, 292 U.S. 16 (1934) (per curiam). *Coleman* Br. 37-38. *Gully* held that "by virtue of its appellate jurisdiction in cases of decrees purporting to be entered pursuant to [a statute requiring particular injunctions to be issued by three-judge district courts]," this Court

"necessarily has jurisdiction to determine whether the court below has acted within the authority conferred by that section and to make such corrective order as may be appropriate ...." 292 U.S. at 18. This Court explained that the case was "analogous to those in which this Court, finding that the court below has acted without jurisdiction, exercises its appellate jurisdiction to correct the improper action." *Id.*

Appellees wrongly suggest that *Gonzalez* v. *Automatic Employees Credit Union*, 419 U.S. 90 (1974), overruled this aspect of *Gully*. *Coleman* Br. 37. In *Gonzalez*, a three-judge court was convened to address a constitutional challenge to a statute, but the court subsequently dismissed the case because the plaintiff lacked standing to raise that challenge. This Court concluded that it lacked jurisdiction to review the *standing decision* on the grounds that it was not "merely short of the ultimate merits; it was also, like an absence of statutory subject-matter jurisdiction, a ground upon which a single judge could have declined to convene a three-judge court, or upon which the three-judge court could have dissolved itself." 419 U.S. at 100; see *id.* at 101 ("when a three-judge court denies a plaintiff injunctive relief on grounds which, if sound, would have justified dissolution of the court ... review of the denial is available only in the court of appeals").

Thus, in *Gonzalez*, this Court lacked jurisdiction under 28 U.S.C. § 1253 to review the three-judge court's decision because the three-judge court never decided any question within its authority *as a three-judge court*. This holding is irrelevant because the three-judge court here issued a prisoner release order, a determination that only the three-judge court could make. 18 U.S.C. § 3626(a)(3)(B). And, it certainly does not undermine *Gully*'s holding that this Court has jurisdiction to decide whether a three-judge court was properly convened once that court issues a decree based on its purported power under the three-judge statute. Finally, *Gonzalez* expressly reaffirmed *Gully*, explaining that this Court "has not hesitated to exercise jurisdiction 'to determine the authority of the court below and "to make such corrective order as may be appropriate to the enforcement of the limitations which [28 U.S.C. § 1253] imposes."'" 419 U.S. at 96 n.12 (quoting *Bailey* v. *Patterson*, 369 U.S. 31, 34 (1962) (per curiam) (quoting *Gully*, 292 U.S. at 18)).

Appellees' *amici* acknowledge that *Gully* remains in force, Br. of *Amici* ACLU et al. 8-9 & n.3, but suggest that under *Gully*, this Court limits its review to jurisdictional questions presented on the face of the complaint. *Id.* at 9-13. Some jurisdictional issues present pure issues of law, while others do not. *Amici* cite cases in the former category, mistakenly treating what is only the particular context of those cases as a limitation on the Court's authority. Neither the cases *amici* cites nor *Gully* (reaffirmed by *Gonzalez* after all cases cited by *amici* were decided) supports the imposition of any such limitation. When this Court reviews the decision of a three-judge court, it has authority to resolve whether that court was properly convened.[1]

2. Appellees further suggest that this Court has evaluated whether a three-judge court had

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[1] Appellees incorrectly assert that the State failed to preserve this jurisdictional issue in its opening brief. *See Coleman* Br. 37. The State's Opening Brief (at 24) cited and relied on both *Gully* and *Gonzalez*. The State also expounded on this issue in its Consolidated Opposition to Appellees' Motions to Dismiss or Affirm 3-4.

jurisdiction only when "the time for appeal ha[s] expired" and "the 'correct procedure' for seeking review of the single-judge court's order was not 'definitely settled.'" *Coleman* Br. 38 (quoting *Oklahoma Gas & Elec. Co.* v. *Oklahoma Packing Co.*, 282 U.S. 386, 392 (1934)). This is inaccurate.

This Court has not based its jurisdiction to decide if a three-judge court was properly convened on whether the "correct procedure" to obtain such review is settled. Instead, this Court has considered that factor in selecting the appropriate corrective action—*i.e.*, whether to dismiss or vacate and remand—*after* determining that the three-judge court was improperly convened. See *Phillips* v. *United States*, 312 U.S. 246, 254 (1941) (court will vacate and remand "where the question of jurisdiction was not obviously settled by prior decisions").[2] Here, in any event, appellees have not shown that it was "obviously" settled that the appeals courts have jurisdiction to review the propriety of convening a three-judge court to address prisoner release.

Finally, any suggestion that this Court should dismiss the appeal if it finds that the three-judge court lacked jurisdiction is wrong. Cf. *Coleman* Br. 38-39. Outright dismissal of this appeal is plainly inappropriate because

> in cases where the subordinate court was without jurisdiction and has improperly given judgment for the plaintiff ... the judgment in the court below must be reversed, else the plaintiff

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[2] "Recent opinions seem to have made such relief [vacatur and remand] almost routine," without discussing whether the Court's jurisdiction was previously settled. 17 Wright & Miller, *Federal Practice and Procedure: Jurisdiction* § 4040 n.33 (3d ed. 2010) (citing *Moody* v. *Flowers*, 387 U.S. 97, 104 (1967)).

> would have the benefit of a judgment rendered by a court which had no authority to hear and determine the matter in controversy.

Assessors v. *Osbornes*, 76 U.S. (9 Wall.) 567, 575 (1869).

3. Our opponents' conflicting views of how defendants obtain review of the three-judge court's authority to order prisoner release undermine rather than advance their claim that this Court lacks jurisdiction.

Appellees and *amici* suggest that review lies in the courts of appeals *after* a prisoner release order issues. *Coleman* Br. 36-37; ACLU Br. 12-13. But, on this view, both this Court—which unquestionably has jurisdiction—and the courts of appeals would simultaneously have jurisdiction. That scenario is inefficient and could lead to conflicting rulings, outcomes which Congress could not have intended.

Moreover, under the PLRA, this Court's authority to review the three-judge court's jurisdiction ensures judicial efficiency. Under the PLRA, if the three-judge court was improperly convened, a prisoner release order is not available from *any* court. 18 U.S.C. § 3626(a)(3)(B). It makes sense, accordingly, for this Court both to resolve the three-judge court's jurisdiction and to review the prisoner release order on its merits.

CCPOA takes a different view entirely. It asserts (at 32-33) that *no* court can ever review the three-judge court's authority. It argues that the question whether § 3626(a)(3)(A)'s requirements were satisfied may harmlessly be treated as unreviewable, because review of the three-judge court's decision under § 3626(a)(3)(E) adequately protects the State's interests. CCPOA is incorrect.

First, § 3626(a)(3)(A) serves an important function, distinct from that served by § 3626(a)(3)(E). It not only prevents the waste of district court resources, CCPOA Br. 33, but also ensures that federal courts do not enter injunctive relief without providing States reasonable time to comply with underlying orders before initiating proceedings involving potentially more intrusive relief. Section 3626(a)(3)(E), in contrast, makes no reference to the safety valve in § 3626(a)(3)(A)—the requirement that a single-judge district court actually provide the State with an adequate opportunity to address a federal violation by other means before the court even considers the extraordinary remedy of prisoner release.

Second, § 3626(a)(3)(A)'s text shows that its requirements are jurisdictional. The statute is directed to the power of the court. 18 U.S.C. § 3626(a)(3)(A) ("no court shall enter a prisoner release order"). See *Landgraf* v. *USI Film Prods.*, 511 U.S. 244, 274 (1994) ("[J]urisdictional statutes speak to the power of the court rather than to the rights or obligations of the parties.") (internal quotation marks omitted). This Court, too, has recognized that the decision whether a three-judge court was properly convened implicates that court's "authority." *Gully*, 292 U.S. at 566; *Bailey*, 369 U.S. at 34.

B. The State Did Not Have A "Reasonable Amount Of Time To Comply" With The Orders At Issue.

The single-judge courts did not afford the State a reasonable amount of time within which to comply with their previous orders, as 18 U.S.C. § 3626(a)(3) requires. Thus, the three-judge court was improperly convened and its prisoner release order must be reversed. The cases should be remanded to the single-judge district courts for any further proceedings.

1. CCPOA (at 27-30) argues that orders such as those creating and implementing a Receivership and requiring coordination between the Special Master and the Receiver are not subject to § 3626(a)(3)(A)'s reasonable-time requirement. The statute, however, requires the court to give the defendant reasonable time to comply with "the previous court orders." 18 U.S.C. § 3626(a)(3)(A). The most natural reading of this provision is that it refers to all the court's previous orders. See Opening Br. 13-16.

CCPOA, however, says that the orders creating and implementing the Receivership and reforming the *Coleman* remedial program are not the kind of orders that require a defendant to "comply." Br. 27-28; compare Opening Br. 15-20 (receivership remedy); *id.* at 20-22 (requirements that the State, *inter alia*, implement revised program guides and other plans, and coordinate efforts with the receiver). CCPOA therefore claims that the respective courts were not required to wait a reasonable time after their issuance before convening three-judge proceedings. Br. 27. This cramped reading of the statute makes no sense, particularly in light of Congress's intent to allow States to try all other avenues before being subjected to a prisoner release order. Both the Receiver (and his plans) and the Special Master (and his plans) are or led to remedial orders issued by the single-judge district courts.

In any event, the remedies in question *do* require State compliance. For example, the orders required not only the appointment of a Receiver, but also the effectuation of the Receiver's plan of action. See *Plata* D.E. 473, at 4; JA 977, 983-84 (order imposing and requiring the State to effectuate the

Receivership); see also, *e.g.*, *Coleman* D.E. 1773, at 2 ("order[ing] defendants to immediately implement [Revised Program Guide] provisions"). The court required the State to "work closely with the Receiver to facilitate the accomplishment of his duties under this Order," *Plata* D.E. 473, at 4; to cooperate fully with the Receiver "in the discharge of his duties"; and to respond promptly "to all inquiries and requests related to compliance with the Court's orders in this case," *id.* at 8; see JA 977 (similar); JA 987 ("imbu[ing] [the Receiver] with the power and authority to act in the name of the Court"). Indeed, CCPOA correctly states (at 29-30): "To be sure, the court was required to determine whether the Receiver could remedy the violations before it convened a three-judge court ...." The only provision requiring any such determination before a three-judge court is convened is § 3626(a)(3)(A).

2. Appellees claim that the State has elevated form over substance by arguing that it is entitled to time to comply with the court's "last" order. *Coleman* Br. 41-42. But the State contends only that the statute requires that it receive reasonable time to comply with the court's "previous orders"; the definition of reasonable time turns on the nature of the order (implementing a receivership requires more time than, *e.g.*, providing data to the court), not on whether a particular order came "last." The Receivership and the revised remedial plan in *Coleman* constitute previous orders of the court, and the State was entitled to reasonable time for compliance.

3. CCPOA also suggests that the court is not required to give the State reasonable time to comply with "merely palliative order[s]" before convening a three-judge court. Br. 23. The comprehensive *Plata*

Receivership and new remedial program under the *Coleman* Special Master cannot be analogized to orders to hire additional nurses (*id.*) or to update a single prison's water system (*id.* at 25). Unlike CCPOA's examples, the remedies here systematically targeted the alleged Eighth Amendment violations. The *Plata* court's statements manifest its view that the Receivership could remedy the overarching violations. JA 917 (Receiver can "bring the delivery of health care in California prisons up to constitutional standards"); *id.* at 983 ("[T]he establishment of a Receivership, along with those actions necessary to effectuate its establishment, are narrowly drawn *to remedy the constitutional violations* at issue ... [and] *correct these violations.*") (emphases added).

CCPOA cites one sentence in the *Plata* court's order convening the three-judge court as a finding that the Receivership remedy could not correct the violation "'unless something is done to address the crowded conditions in California's prisons.'" Br. 30. The convening order as a whole does not support this proposition. The court noted that overcrowding was a "substantial impediment" to the Receiver's work, concluding that population limits could speed up the process. JS1-App. 281a-283a. But these observations do not suggest that failure of the Receivership was a foregone conclusion. And to the extent they suggest that the State was not entitled to reasonable time to comply with the Receiver's plan before any prisoner release order, they would be clearly wrong. Indeed, the conditions the court highlighted as affected by crowding, JS1-App. 282a, are among those that have markedly improved without any population reduction. See Opening Br. 17-19.

Likewise, CCPOA's reliance (at 30-31) on the *Coleman* court's statement that crowding was preventing constitutionally adequate mental health care, JS1-App. 304a, is misplaced. That statement was not made in connection with the relevant orders for relief—the new remedial program and coordination with the Receiver, see Opening Br. 20-22—and the court was not passing judgment on whether those specific remedies had a likelihood of eventual success sufficient to require that the State have reasonable time to comply. Indeed, the State's previous progress in addressing the conditions at issue in *Coleman* in the face of crowding strongly supports the inference that these new remedies could have borne fruit given a fair opportunity. See JS1-App. 293a-294a. The district court acknowledged that between 1997 and 2005, the State made "commendable progress" under the Special Master. *Id.* at 294a. Yet, the prison population in 2001, for example, differed by only several thousand inmates from that in 2006 and 2007. See, *e.g.*, *id.* at 54a, 52a.

4. The State was entitled to a reasonable amount of time to comply with the above-discussed remedies, *supra* at 7-11, and the single-judge courts failed to provide such time. See Opening Br. 14-24.[3]

In response to the State's showings, the *Plata* appellees rely heavily on the three-judge court's (incorrect) finding that no other relief will remedy the violation; but it is the single-judge court that was required to find that the State had reasonable time to comply. Critically, the single-judge court expressly determined that it was *not required to wait a reasonable time* after appointing the Receiver to convene the three-judge court. JS1-App. 281a; see Opening Br. 14-15.

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[3] Appellees and CCPOA disagree about the standard of review applicable to this reasonableness inquiry. *Compare* CCPOA Br. 30 (clear error), *with Coleman* Br. 40 *and* Plata Br. 28 (abuse of discretion). This inquiry involves mixed questions of law and fact, and *de novo* review is appropriate. *Infra* at 15-17.

Appellees highlight the single-judge court's statement that it gave "'defendants every reasonable opportunity to bring its prison medical system up to constitutional standards.'" *Plata* Br. 29. But they omit that the court quoted this statement from its *October 2005* order justifying appointment of a Receiver, and failed to find that the State had been given the required opportunity *after* that appointment. See Opening Br. 15 (findings were based on June 2002 and September 2004 orders). Moreover, the *Plata* court acknowledged the Receiver's conclusion that his Plan of Action would work without population reductions and that population controls would not solve California's prison health care problems. JS1-App. 282a. The Receiver explained only that "'population limits may help effectuate a *more timely and cost effective* remedial process,'" not that his plan would fail if given a reasonable amount of time. *Id.* (emphasis added, alteration omitted).

The *Coleman* court, too, failed to address whether the State had a reasonable opportunity to comply with the newly revised remedial program, including the newly required coordination between the Special Master and the Receiver. See JS1-App. 292a-297a. In its one-paragraph discussion of the reasonable-time requirement, the court noted only that it had issued orders over a number of years. *Id.* at 297a. The court failed to acknowledge that the plaintiffs moved to convene three-judge proceedings only five months after the State was directed to coordinate its

Coleman remedial efforts with the Receiver and that the court ordered those proceedings just over one year after such coordination began.

Had the single-judge courts decided that the State had received a reasonable time to comply with the relevant orders, those decisions would have been erroneous. Opening Br. at 16-20, 22-24. The *Plata* appellees do not dispute that the Receiver has emphasized the State's progress, *id.* at 17-18; that the State has significantly increased funding and staffing, finalized construction plans and started construction, and enhanced infrastructure, *id.* at 18-19, 37; and that death rates have dropped, *id.* at 19-20. Although appellees note the decreased health care budget for 2010, *Plata* Br. 32 n.6, they do not dispute the massive influx of funds for prison healthcare during the past two years. Appellees argue only that the State's improvements did not remedy the violations. *Id.* at 32. The relevant inquiry here, however, is whether the State had a reasonable amount of time to comply with the most recent structural orders before a three-judge court properly could be convened. The numerous significant improvements show that the two months between when the Receiver's initial plan issued and three-judge proceedings were convened was not a reasonable period of time to allow the court to conclude that the Receivership remedy had failed, particularly when the Receiver himself anticipated a multi-year process.

Similarly, the *Coleman* appellees do not dispute that the State has made significant progress. They assert (at 44) that "most of the improvements represent aspirational plans, not concrete results," but they fail to address the State's evidence of significantly reduced vacancy rates for psychologists, Opening Br. 23; the addition of designated mental-health beds, *id.* at 23-24; and decreases in the number of suicides, *id.* at 24; see also JA 1457-80, 1489-93 (detailing improvements). Given the State's progress on multiple fronts under the new remedial program and the coordinated efforts of the Special Master and the Receiver, the single-judge court erred by convening the three-judge court when it did.[4]

5. Finally, the State showed that the three-judge court's order is based on the combined cases of two plaintiff classes, and that if only one of the proceedings was properly instituted, the order must be reversed as to both classes. Opening Br. 24-25. In response, appellees cite class-specific observations and findings, such as those addressing mental health issues. *Coleman* Br. 45. But, regardless of what specifics were noted, the *merits determinations* at issue (under § 3626(a)(3)(E) and the choice of remedy) are unitary, making no distinction between the two classes.[5]

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[4] Contrary to *amici*'s assertion (ACLU Br. 13-14), because the court lacked authority to enter the order in question, harmless error review does not apply. *Torres* v. *Oakland Scavenger Co.*, 487 U.S. 312, 317 n.3 (1988) ("[A] litigant's failure to clear a jurisdictional hurdle can never be 'harmless' or waived by a court.").

[5] If three-judge proceedings were proper in only one case, the Ninth Circuit's Chief Judge must be allowed to effectuate the requirements of 28 U.S.C. § 2284(b)(1). The State did not waive this argument by failing to object previously, *see* CCPOA Br. 35, because the objection is ripe only if this Court holds that one of the single-judge courts improperly convened three-judge proceedings.

II. SECTION 3626(a)(3)(E)'S REQUIREMENTS HAVE NOT BEEN SATISFIED.

A. The Question Presented Is Reviewed *De Novo*.

Appellees incorrectly contend that the second question presented is reviewed for clear error. *Coleman* Br. i ¶ 2; *Plata* Br. 46; see also *supra* note 3.

As the district court recognized, JS1-App. 126a n.55, "'the primary cause issue is ultimately a question of law.'" Moreover, any application of § 3626(a)(3)(E) presents mixed questions of law and fact. Such questions are subject either to *de novo* or abuse-of-discretion review. See *Pullman Standard* v. *Swint*, 456 U.S. 273, 289 n.19 (1982) (independent review); *Pierce* v. *Underwood*, 487 U.S. 552, 559-60 (1988) (abuse-of-discretion). Here, the case for *de novo* review is strong.

This Court has held that "independent" or *de novo* review is warranted "[w]hen the standard governing the decision of a particular case is provided by the Constitution." *Bose Corp.* v. *Consumers Union of U.S., Inc.*, 466 U.S. 485, 503-06 (1984).[6] Here, the legal issues under § 3626(a)(3)(E) are whether crowding is the "primary cause" of Eighth Amendment violations and whether any relief other than prisoner release will remedy those violations. The statutory interpretation is inextricably intertwined with the claimed constitutional violations. Opening Br. 28. Thus, "[i]ndependent review is ... necessary if appellate courts are to maintain control of, and to clarify, the legal principles" underlying such Eighth Amendment-based claims. *Ornelas*, 517 U.S. at 697. See also, *e.g.*, *Graham* v. *Florida*, 130 S. Ct. 2011, 2026 (2010) (citing the importance of "[t]he judicial exercise of independent judgment" in the Eighth Amendment setting). *De novo* review is also appropriate in this case because of the extraordinary nature of the relief being requested. A prisoner release order is the most extreme action a federal court can take *vis-à-vis* the State's penal system. Such relief should only be ordered when this Court is convinced that the predicate requirements of the statute are fully supported by the record.

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[6] *See, e.g.*, *Cooper Indus.* v. *Leatherman Tool Grp.*, 532 U.S. 424, 435-36 (2001); *Lilly* v. *Virginia*, 527 U.S. 116, 136 (1999) (plurality opinion); *Ornelas* v. *United States*, 517 U.S. 690, 697-98 (1996); *Miller* v. *Fenton*, 474 U.S. 104, 112-13 (1985); *see also* *Wright* v. *West*, 505 U.S. 277, 306-07 (1992) (plurality opinion) (Kennedy, J., concurring).

Additionally, the timing of the remedial order here means that this Court necessarily will undertake an independent evaluation. The three-judge court determined whether prisoner release was appropriate based on the August 2008 record, instead of examining the facts in January 2010, when the order on appeal issued. See Opening Br. 7, 26-30 & n.9. Any injunction must be based on the need to remedy current harms. See *id.*; 18 U.S.C. § 3626(a)(3)(E); see also *City of L.A.* v. *Lyons*, 461 U.S. 95, 101-02 (1983) (requiring a "'real and immediate'" threat of injury). To make these determinations, a court must examine the facts at the time the injunction would issue. The court below, however, declined to account for any developments after August 2008, even though current conditions are well-documented in filings by the Receiver and the Special Master in the constituent cases, and in judicially noticeable reports of the Receiver and the Office of the Inspector General. Accordingly, this Court of necessity will be conducting an "independent review," which for practical reasons should extend to the entire case.

Appellees incorrectly contend that this Court should not consider ongoing case developments. See *Coleman* Br. 34-35; *Plata* Br. 14 n.3. But, this Court, like other appellate courts, may "take account of developments in the case subsequent to proceedings in the trial court," when warranted. 21B Wright & Graham, Jr., *Federal Practice and Procedure* § 5110.1 (2d ed. 2010).[7] Indeed, in *Inmates of Occoquan* v. *Barry*, the court vacated a prisoner release order where, as here, "the record [wa]s already stale" by the time of appeal. 844 F.2d 828, 840 (D.C. Cir. 1988). In doing so, the appeals court credited the defendant's representations that "it has already addressed and remedied many (if not all) of the specific 'deficiencies' enumerated by the trial court," and relied on "reports of actual improvements described in the record" post-dating the order on review. *Id.* at 840 & n.17. These principles apply equally here.

B. Appellees Are Not Entitled To A Prisoner Release Order.

Appellees' interpretations of § 3626(a)(3)(E) are incorrect, and that section's prerequisites to prisoner release were not satisfied here.

1. Appellees' mantra is that if this prisoner release order does not satisfy the PLRA, none ever will. See,

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[7] *See, e.g.*, *Riley* v. *Kennedy*, 553 U.S. 406, 417-18 & n.4 (2008) (discussing facts post-dating the appealed order); *Honig* v. *Students of Cal. Sch. for the Blind*, 471 U.S. 148 (1985) (per curiam) (finding issue moot due to compliance with injunction over dissent's objection that "the facts making it moot occurred subsequent to the Court of Appeals decision, and so do not appear on the record").

e.g., *Coleman* Br. at 29-31, 61; *Plata* Br. 57; CCPOA Br. 19. Appellees, however, underestimate the arsenal of structural remedies available to federal courts, which are required to respect Congress's decision that a prisoner release order may not issue until it is certain that every other remedy has failed and will fail. When, and only if, these remedies fail can prisoner release be justified.

Here, for example, the single-judge district courts decided to impose structural remedies in the form of a Receivership that controls nearly every aspect of the State's delivery of medical care to prisoners and a comprehensive remedial regime to be implemented under the Special Master with required coordination with the Receivership. Had these remedies been given a fair opportunity to succeed, but had led to a regression (rather than producing substantial progress), the argument for prisoner release would unquestionably be stronger. This appeal does not present that scenario.

2. Appellees' interpretations of § 3626(a)(3)(E) refuse to accept that Congress significantly raised the bar for obtaining prisoner release.

Pre-PLRA, inmates were required to demonstrate proximate causation to prevail on Eighth Amendment claims, and to be entitled to a remedy directed at crowding. See, *e.g.*, Opening Br. 32; *Leer* v. *Murphy*, 844 F.2d 628, 634 (9th Cir. 1988) (plaintiff must show "actual and proximate cause"); *Morgan* v. *Dist. of Columbia*, 824 F.2d 1049, 1058 (D.C. Cir. 1987); *cf.* CCPOA Br. 41-42. Indeed, prisoner release was already the remedy "of last resort." *E.g.*, *Plyler* v. *Evatt*, 924 F.2d 1321, 1329 (4th Cir. 1991) (early release is a "draconian last alternative"). Yet, in the PLRA, Congress sought to impose *additional* limits on the availability of prisoner release orders, see

Opening Br. 4-5, 32, 51a; Br. of *Amici* Louisiana et al. 6-8. Thus, an even more rigorous application of the proximate causation standard is required. Opening Br. 31. The court below did not apply a heightened standard.[8]

Appellees, however, contend that a "long line of precedents" supports their argument that "primary cause" is a less stringent requirement than proximate cause. *Coleman* Br. 47. The *two* cases they cite do not prove that point.

First, they rely on *New York Central Railroad* v. *White*, 243 U.S. 188, 205 (1917). In *White*, this Court interpreted workers' compensation laws, which made the employer strictly liable for employees' workplace injuries. The Court stated that "[i]n excluding the question of fault as a cause of the injury, the act in effect disregards the proximate cause and looks to one more remote—the primary cause, as it may be deemed—and that is, the employment itself." *Id.* In other words, where a statute imposes strict liability based on status, that status is the primary (*i.e.*, only) cause of liability, and the precipitating or actual cause of any injury is irrelevant to fault.

The PLRA plainly is not using the word "primary" in this sense; it does not impose strict liability (*i.e.*, allow a release order) based solely on crowding. To the contrary, it indisputably heightens the standard for prisoner release, requiring that it be the actual, or precipitating cause of the alleged constitutional violation.

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[8] Appellees incorrectly contend that the State's statutory construction constitutes a "new claim" that is forfeited, *Coleman* Br. 46. The State is not making a new claim; it is proffering an additional "argument to support of what has been [a] consistent claim" that § 3626(a)(3)(E)(i)'s "primary cause" requirement is not satisfied. *Lebron* v. *Nat'l R.R. Passenger Corp.*, 513 U.S. 374, 379 (1995).

Next, appellees cite *United States* v. *Hatfield*, 591 F.3d 945 (7th Cir. 2010), a decision that sheds no light on the meaning of "primary cause" here. In *Hatfield*, the court struck down as confusing a jury instruction explaining when death or serious bodily injury "results from" use of a controlled substance. The instruction simultaneously stated that the controlled substance (i) must be "'a factor that resulted in'" death or injury, (ii) "'need not be the primary cause of'" such death or injury, but (iii) "'must have at least have played a part in'" the death or injury. *Id.* at 947. The court thought the instruction should have simply used the term "results in," and explained that the concept of causation is context-specific and driven by the policy needs of particular circumstances. Its most definitive statement about "primary cause" was that in *Black's Law Dictionary*, it is "a synonym for 'proximate cause.'" *Id.* at 949.

3. Appellees argue that the three-judge court properly applied § 3626(a)(3)(E) without assessing the current state of alleged Eighth Amendment violations. Otherwise, they say, the three-judge court would be "re-determin[ing] liability during the *remedial phase*." *Plata* Br. 33 (emphasis added). That contention rests on a false premise.

Under the PLRA, proceedings before a three-judge court are not analogous to a "remedy phase." They are a separate liability phase in which plaintiffs must make a particularized showing of liability to become eligible for an exceptional remedy. Here, this particularized liability inquiry occurred more than a decade after the first-phase liability finding in *Coleman* and more than five years after the finding in

Plata; in those early phases, moreover, crowding was irrelevant to liability.

Neither this Court nor the three-judge court below can reasonably conclude that crowding is the primary cause of Eighth Amendment liability today, based on the liability findings made in 1994 and 2002. See *Coleman* Br. 33-34; Opening Br. 5-6. Conditions changed substantially between the initial findings of liability and entry of the January 2010 prisoner release order. Opening Br. 17-21, 26-30, 37-39.[9] When issuing an injunction, particularly one for prisoner release, "'the nature of the ... remedy is to be determined by the nature and scope of the constitutional violation.'" *Missouri* v. *Jenkins*, 515 U.S. 70, 88-89 (1995) (quoting *Milliken* v. *Bradley*, 433 U.S. 267, 280 (1977)); see *Milliken*, 433 U.S. at 281-82. The issuance (and scope, *infra* § III) of such an order must be based on the current state of alleged Eighth Amendment violations.

4. In determining whether crowding is the "primary cause" of constitutional violations here, it is appellees' arguments, not the State's, that are

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[9] Plainly, the State's numerous efforts and investments mean that today it is differently situated with respect to the Eighth Amendment's requirement of deliberate indifference. Opening Br. 29. In fact, that requirement has never been adjudicated in *Plata*. JA 889-90, ¶ 4 (consent decree does not address subjective requirement); *cf. Horne* v. *Flores*, 129 S. Ct. 2579, 2594 (2009) ("public officials sometimes consent to ... decrees that go well beyond what is required by federal law"). Indeed, appellees' *amici* suggest that release orders should be subject to additional scrutiny where, as here, they turn on "decree[s] ... entered by consent ... in the absence of any *judicial* finding of a constitutional violation." ACLU Br. 7 (emphasis added) (discussing Congress's concern about a pre-PLRA consent decree that led to a population cap).

inconsistent with the record. Contra *Coleman* Br. 27, 34; *Plata* Br. 24.

In discussing inmates' injuries and deaths over the years, appellees manipulate the record to attribute these events to crowding and then wrongly imply that crowding is the "primary cause" of injuries currently being incurred. See *Plata* Br. 7-10. For instance, appellees suggest that crowding caused a patient's October 2007 death that the Receiver considered "likely preventable." *Id.* at 9 (discussing JA 2042-43). The report in question notes "prison medical staff['s] 'fail[ure] to properly evaluate'" the patient's symptoms and a lack of "communication between the discharging physician and the receiving physician" as appellees suggest. *Id.* at 8-9 (quoting Def. Ex. 1233 at 14 [JA 2042] and citing JA 2042-43). But it says nothing about crowding and does not suggest that an "overwhelmed ... prisons' medical records system" was the cause. Compare *id.*, with JA 2042-43. Appellees also fail to mention the report's statement that a *civilian* (*i.e.*, *non*-prison) hospital discharged the patient to CDCR without giving the State's physicians sufficient instruction, JA 2042-43, and that the patient died at a *second civilian* hospital as a consequence of the omissions of the first civilian hospital, *id.* at 2043; see also *id.* at 2042-43 (documenting other errors by the first hospital).

Similarly, appellees imply that crowding caused delayed care and a preventable death in 2006. *Plata* Br. 10 (citing JA 1999). Yet, they do not include the report's explanation that the delay resulted, *not* from crowding, but from the failure of an individual physician to report to the facility while on call. JA 1999.[10]

Moreover, the general claim that preventable deaths in the CDCR system demonstrate that *crowding* is the primary cause of Eighth Amendment violations is untenable. Here, it is undisputed that the level of preventable deaths in CDCR today is comparable to, or better than, the norm for even non-prison medical care. See Tr. 1204:23-1206:5 (testimony based on Institute of Medicine study that as many as 98,000 preventable deaths occur in United States hospitals every year); Instit. of Med., *To Err is Human* 26 (L.T. Kohn et al., eds., 2000) ("deaths in hospitals due to preventable adverse events exceed the number attributable to the 8th-leading cause of death"); see also Cal. Prison Receivership, *Analysis of Year 2009 Death Reviews* 8 (Sept. 2010) ("*2009 Death Review*") (lapses in care are "unavoidable" in the non-prison healthcare setting and lead to injury). The Receiver has pointed to studies suggesting that up to 6% of all civilian hospital deaths are "definitely preventable," and 23% are "possibly preventable." Cal. Prison Receivership, *Analysis of Year 2008 Death Reviews* 6 (Dec. 14, 2009) ("*2008 Death Review*") & *2009 Death Review* at 4.

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[10] The *Coleman* appellees take similar liberties. Br. 15 (discussing JS1-App. 98a and JA 492-627). For example, they describe their expert's experience with a mentally ill patient at Wasco State Prison ("WSP") on August 1, *2008* and attribute poor care to crowding and staffing shortages. See *id.*; JA 585-86. They ignore, however, that WSP remains crowded (196.7% of design capacity, *see* CDCR, *Monthly Report of Population* 2 (Jan. 5, 2010) ("*Monthly Report of Population*"), and yet fulfilled 97% of inmates' mental health care appointments in December 2009 (4,141 total appointments). *See* Fed. Receiver, *Turnaround Plan of Action: Monthly Report* 12 (Feb. 28, 2010) (hereinafter "*Receiver's Monthly Report(s)*"). Of the 83 inmates not seen, none was due to "not enough holding space"; the majority resulted from provider-specific cancellations (46 total). *Id.*; *see also* Office of the Inspector General (OIG), *Wasco State Prison Medical Inspection Results* 1 (Nov. 4, 2010) (awarding institution 75.9% of the total points possible for adherence to Receiver's policies and procedures).

In the Receiver's most recent annual death review, he classified just three inmate deaths (of 395 total) as "likely preventable," *i.e.*, .07%. *2009 Death Review* at 13; see *id.* at 11 (43 or 11% of the deaths were "possibly preventable").[11] The three "likely preventable deaths" included one in which the inmate-patient was treated and died in a civilian hospital, *id.* at 14, and another in which the inmate died from head trauma due to a failure to protect the patient from injury during transportation, *id.* at 13. Compare *Plata* Br. 9 (citing *2009 Death Report* at 13 regarding the third death, wrongly implying that it was related to crowding because it "could have been prevented by timely specialist care"). Notably, moreover, approximately 400,000 medical and mental health appointments occur *every month* in the State's prisons. See, *e.g.*, *Receiver's Monthly Report* 4 (Oct. 31, 2010); *Receiver's Monthly Report* 4 (Dec. 30, 2009). Nonetheless, the rate of death and the number of suicides have declined significantly in recent years. Opening Br. 24; compare *Coleman* Br. 14 (relying on increase in suicides in 2006, but ignoring newly launched suicide prevention programs, see Opening

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[11] Even if a preponderance standard applied, the court could not rely on "possibly preventable deaths" to show that crowding currently is the "primary cause" of Eighth Amendment violations. *See Plata* Br. 7 (relying on such deaths); JS1-App. 9a, 123a-124a (same); *Saelzler* v. *Advanced Group 400*, 23 P.3d 1143, 1152 (Cal. 2001) ("'mere possibility of ... causation is not enough'").

Br. 21-22 & n.5, and falling rates).[12] As the Receiver's most recent death review explained, "t[he] significant reduction in the number of attributed preventable deaths in 2009 continues a trend which shows that the overall quality of care in the California prison system is improving." *2009 Death Review* at 20. While CDCR continues to face challenges in this area, the relevant evidence does not demonstrate that crowding is proximately or primarily causing the alleged denial of the plaintiff-classes' Eighth Amendment rights.

5. The Receiver's *Amicus* brief and previous filings do not support a holding that crowding is the "primary cause" of any constitutional violations.

The Receiver first claims that although "facilitat[ing] inmate access to care for previously scheduled appointments" has been "successful," it "does not guarantee that all other elements of the plan will be equally successful at current population density levels." Receiver Br. 12. But, of course, appellees had the burden of showing that other elements of the plan would *not* be successful due to crowding. 18 U.S.C. § 3626(a)(3)(E)(ii). More significantly, the State's success in providing inmate access despite crowding illustrates why § 3626(a)(3)(E) has not been satisfied.

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[12] Indeed, the rates of "likely preventable" and "possibly preventable" deaths in the CDCR system have been consistently low for years. *2008 Death Review* at 8-9 (five (*i.e.*, 1%) of 369 total deaths reviewed were likely preventable and 61 (17%) were possibly preventable); JA 2034 (*2007 Death Review*) (stating that three (1%) of 395 reviewed deaths were "preventable" and 65 (16%) were "possibly preventable"); *but cf.* JA 1995-96 (*2006 Death Review*) (18 (or 4.7%) of 381 reviewed deaths were adjudged "preventable" and 48 (12.6%) were classified as "possibly preventable").

Specifically, the access the Receiver now describes as "one small element" of his plan, Receiver Br. 12, is depicted in markedly different terms in the Receiver's Turnaround Plan of Action and subsequent reporting. The Turnaround Plan stated that "our mission is a simple one: Reduce avoidable deaths and illness," JA 1134, explaining:

> Constitutionally adequate health care occurs when patient-inmates are given
>
> - *timely access* to competent medical and clinical personnel ... and
>
> - *timely access* to prescribed medications, treatment modalities, specialists and appropriate levels of care.

Id. at 1125 (emphases added); see *id.* at 1136 ("Goal 1. Ensure Timely Access to Health Care Services"). The Receiver's staff also noted that delayed access to care can contribute to potentially preventable deaths, and concluded that *the most important steps for reducing such delays* were the Receiver's (1) "access-to-care initiative" and (2) "health care access units"—*not* population reduction. JA 2051-53 (*2007 Death Review*) (capitalization omitted); see also *Plata* Br. 7-10 (relying on the same document). These two important initiatives are those that the Receiver has described as successes which "will have the necessary resources to support healthcare operations at the current level of service." JA 1555; see also JA 1655 (the State "continue[s] to be highly effective in facilitating inmate access to scheduled appointments"); Opening Br. 19.

The State recognizes that the "required timelines for access" are not satisfied in all circumstances. Receiver Br. 12 (pointing to an OIG report identifying a "'comparatively low'" score on an access measure).[13] But those findings do not show that crowding is "the primary cause" of unconstitutional care or that the number and extent of any delays rise to a level of unconstitutionality. See OIG, *Summary & Analysis* at 1. Missed timelines do not constitute Eighth Amendment violations. See *Wilson* v. *Seiter*, 501 U.S. 294, 298 (1991) (deprivation objectively must be "sufficiently serious"). In the same OIG report, moreover, facilities scored very high on more constitutionally significant individual categories measuring access. For instance, 13 of 15 institutions scored 100% on whether emergency "medical staff arrive[d] on scene in five minutes or less." OIG, *Summary & Analysis* at 124, 128 (category 15.282).

Additionally, the Receiver attempts to step back from his statement that he could "provide constitutional levels of care no matter what the population is," counterintuitively asserting that the statement was conditioned on acceptance of his former construction plan. Br. 9-10.[14] The Receiver

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[13] The OIG report in question concerns the first round of inspections of CDCR facilities, which were completed between September 2008 and October 2009. OIG, *Summary & Analysis of the First 17 Medical Inspections of California Prisons* 1 (Aug. 2010) ("OIG, *Summary & Analysis*"). Many facilities subsequently have been evaluated and typically have achieved higher scores. *See infra* at 35 & n.16. Moreover, despite the Receiver's statement that OIG's scores on some access measures reflect the effect of crowding, *see* Receiver Br. 12, the 143-page OIG report does not mention crowding or overpopulation or attribute delays in access to those factors.

[14] The Receiver's willingness to share his thoughts here, when the State was not allowed to obtain his views or testimony below, is deeply unfair. Opening Br. 27-28 & n.9.

Additionally, appellees' claims that the State did not sufficiently preserve its challenges to the limitations the district stops short of saying that he cannot provide care that comports with the Eighth Amendment at the population levels that will result after the facilities are expanded under current plans. *Id.* at 11. Any doubt on this issue should be resolved against appellees. 18 U.S.C. § 3626(a)(3)(E)(ii).

Finally, the Receiver does not address whether the State's current conduct constitutes "deliberate indifference" to a substantial risk of significant harm to the plaintiff-classes. See *Seiter*, 501 U.S. at 302-04; *supra* at 21 & n.9. The State's recent $2.35 billion expenditure on prison care and other efforts belie any such claim. See Opening Br. 18-19, 29-30.

6. Section 3626(a)(3)(E)(ii) authorizes prisoner release only if two conditions are satisfied: "no other relief will remedy" the constitutional violation and crowding is its "primary cause." The State reads the two requirements in tandem to mean that "eliminating crowding should undo all or virtually all the constitutional harm." Opening Br. 33 (*quoted, in part, in Coleman* Br. 47). That is the best reading of the provisions because it gives independent meaning to each prong. Indeed, under the State's

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court placed on its ability to obtain testimony or evidence from the Receiver and the Special Master are baseless. *Plata* Br. 36-37 n.8; *Coleman* Br. 49-50. After the court precluded the State from deposing the Receiver, *see* Opening Br. 7, 28 n.9, it categorically held that "both the Plata Receiver and the Coleman Special Master have assumed duties and obligations of a judicial officer and are acting as surrogates of the *Plata* and *Coleman* courts, respectively." JA 1115. It emphasized "[n]othing in this order shall be construed ... to permit any party to these proceedings to request formal testimony from the Receiver or the Special Master or any of their staff members *at any stage of these proceedings*." *Id.* (emphasis added). Pressing an objection further would have been futile. *Cf. MedImmune, Inc.* v. *Genentech, Inc.*, 549 U.S. 118, 125 (2007).

interpretation a release order is truly a remedy of last resort, because the three-judge court would specifically determine what level of reduction is necessary to extinguish any violations which remain after all other avenues have been pursued.

In contrast, appellees fail to offer any reading that gives § 3626(a)(3)(E)(ii) independent meaning. Their reading also leads to results incompatible with Congress's intent.

First, under appellees' interpretation, any time crowding is impeding multiple remedial efforts (as it nearly always will, see Opening Br. 33-34 n.11), § 3626(a)(3)(E) will be satisfied and prisoner release may be ordered.

Second, under appellees' interpretation, release can be ordered whenever lesser measures have failed, regardless of whether the release order itself would "remedy" the alleged federal violation. See, *e.g.*, CCPOA Br. 36-38, 45-46; *Plata* Br. 41, 45-46; *Coleman* Br. 47-48. This reading collapses § 3626(a)(3)(E)'s second prong into the first, making the inquiry entirely about "primary causation," and authorizing prisoner release that will achieve no purpose. A prisoner release order that fails to remedy the alleged constitutional violation is not a remedy at all. Indeed, the PLRA requires that any release order must be the narrowest, least intrusive means to "*remedy*" and "*to correct* the violation of the Federal right." 18 U.S.C. §§ 3626(a)(1)(A), 3626(a)(3)(E)(ii) (emphases added); cf. *Plata* Br. 31. Yet, here, if the release order is fully implemented, that will not itself "remedy" or extinguish the alleged constitutional violations. JS1-App. 134a, 143a; see Opening Br. 30, 33-35; *id.* at 34 (Special Master's belief that release of 100,000 inmates would not remedy the alleged violations).

CCPOA, too, claims that no other relief can remedy the constitutional violations because single-judge courts "could at most provide only partial alleviation of the unconstitutional conditions." Br. 18. Likewise, however, as appellees and the district court recognize, the prisoner release order can do no more than that. This is why crowding is, at most, *a* contributory cause rather than "*the* primary cause" of any constitutional violation, 18 U.S.C. § 3626(a)(3)(E)(i) (emphasis added), and why appellees have not shown that "no other relief will remedy" the violations.

Third, appellees concede that it will be necessary for these cases to return to the single-judge courts for more injunctive relief in addition to the release order. *Plata* Br. 41-42; *Coleman* Br. 50-53; CCPOA Br. 44, 50-51; Tr. 2933:23-2940:22; *accord* JS1-App. 134a. That concession reveals that their interpretation of § 3626(a)(3)(E) defeats Congress's intent to make prisoner release orders the "'remedy of last resort.'" JS1-App. 73a; *Coleman* Br. 30. It instead makes a prisoner release order no more than a way station. Congress required the courts to allow less intrusive remedies to run their course and authorized prisoner release only if other, fully-implemented remedies failed to cure federal violations. See *Women Prisoners of D.C. Dep't of Corrections* v. *Dist. of Columbia*, 93 F.3d 910, 929 (D.C. Cir. 1996) (reversing prisoner release order pre-PLRA because "[t]he court ... should have determined the constitutional propriety of a population cap *at the margin*—that is to say, after its instructions [regarding lesser injunctive relief] had been complied with"); cf. *Occoquan*, 844 F.2d at 843 (prisoner release order cannot be used "as 'a last resort remedy as a first step'").

III. THE 137.5% POPULATION CAP IS NOT NARROWLY TAILORED.

A. Appellees' Nexus And Narrow Tailoring Arguments Are Fanciful.

In its Opening Brief, the State showed that the district court should be reversed because its population cap of 137.5% of the institutions' design capacity cap lacks any nexus to the alleged Eighth Amendment violations, and fails to satisfy the PLRA's heightened tailoring requirements. Opening Br. 40-53. Appellees' contrary arguments are wrong. See *Coleman* Br. 55-58; *Plata* Br. 49-55; CCPOA Br. 53-56.

1. Appellees first suggest that the 137.5% cap was "justified ... based on the evidence at trial." *Coleman* Br. 55. See also *Plata* Br. 50-51 (claiming "voluminous" supporting evidence). But appellees failed to connect the 137.5% cap to the alleged Eighth Amendment violations against the plaintiff-classes. Appellees' request for a 130% cap was based on policy concerns, not the Eighth Amendment:

- the (unmet) goals of the Federal Bureau of Prisons, see Opening Br. 42-44;
- California government staff's aspirations for implementing a recently enacted construction plan (neither the legislation nor the implementation plans related to Eighth Amendment standards), see *id.* at 43; JA 1786-87, 1793; JA 1783-85.
- a group of wardens' study recommending population reductions to achieve a range of policy concerns (not Eighth Amendment requirements), see Opening Br. 44-45; JA 1794-96; and
- expert testimony based on the above

> recommendations (and unconnected to the Eighth Amendment), see Opening Br. 45-47; *id.* at 47-50 ("reasonableness" testimony).

Accord Plata Br. 49-50 (referring to the same professional standards evidence identified by the State); *Coleman* Br. 55 (same).

2. Appellees claim that the remedy satisfied the PLRA's narrow-tailoring requirements because it resembled the Governor's previous population reduction proposals. See *Plata* Br. 50; *Coleman* Br. 55. But the Governor's public policy goals for California's prison are not coextensive with the actions *necessary* to remedy the alleged Eighth Amendment violations at issue. See, *e.g.*, *Chapman*, 452 U.S. at 351-52 & n.16.

3. Appellees also assert that the State cannot object to the 137.5% cap because it did not propose a different cap. *Plata* Br. 50; *Coleman* Br. 55. But appellees bear the burden of demonstrating that the 137.5% cap is narrowly tailored; they cite no authority that supports shifting that burden to the State.

Appellees' related claim that the "[t]he State never challenged the 137.5% number," *Coleman* Br. 55, ignores the fact that the three-judge court came up with that number *after* trial. JS1-App. 184a. The court did so by splitting the difference between plaintiffs' proposed 130% cap and a 145% figure proposed years before trial by professionals in a context unrelated to Eighth Amendment concerns. *Id.*

Neither appellees nor the district court linked either the 130% or 145% figures to the Eighth Amendment. Appellees claim that the 130% figure is narrowly tailored because State prison officials recommended it after "consider[ing] the federal standard" and conducting a study. *Plata* Br. 52 n.17. However, the question the State studied was not whether that prison population remedied Eighth Amendment violations, but how best to implement new construction plans. JA 1786, 1794-96.[15]

Similarly perplexing are appellees' arguments that the 145% cap proposed by a professional panel as "maximum operable capacity" is a relevant constitutional benchmark. *Plata* Br. 53. The recommendation had nothing to do with the Eighth Amendment. JA 1759-63, 1771 n.3; Opening Br. 44-45; JS1-App. 59a, 182a-184a. It sought to achieve policy goals. Opening Br. 44-45. By including those goals in the recommended population cap, the authors' professional, not constitutional, recommendation was inflated, an error that infected the decision below.

4. Independent of their failure to show that the 137.5% cap is narrowly tailored, appellees' arguments that a systemwide population cap is appropriate also fall short.

Preliminarily, appellees incorrectly claim that the State "rejected relief focused solely on the classes" and "argu[ed] that the three-judge court should *exempt* mentally ill prisoners from any population reduction order," but appellees (like the court below) fail to identify any such statement. *Coleman* Br. 56 (citing JS1-App. 236a). They distort the State's observation that release of seriously mentally ill inmates was likely to create special dangers because of their recidivism rates, which is relevant to the PLRA's public-safety inquiry. *Plata* D.E. 2031, ¶¶ 109-111; JA 2479-80, 2538-39.

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[15] The court states: "we cannot determine from the evidence whether the national standard selected by the Governor's strike team represents a judgment regarding the mandates of the Constitution or whether it merely reflects a policy that ensures desirable prison conditions." JS1-App. 183a-184a. There was *no indication or evidence* that it was the former. Professional recommendations are not a proxy for Eighth Amendment requirements. *E.g.*, *Chapman*, 452 U.S. at 348 n.14; *cf.* *Bobby* v. *Van Hook*, 130 S. Ct. 13, 16-17 (2009) (per curiam); *id.* at 20 (Alito, J., concurring).

Next, appellees claim that systemwide relief satisfies the narrow tailoring requirements because the district court found that Eighth Amendment violations exist throughout the California prison system. *Plata* Br. 54 (citing JS-1 App. 171a). Below, however, the State showed that individual institutions were differently situated as to any constitutional violations at the time of trial, Opening Br. 50-53, and its showing was based on more than "one sentence from the cross-examination of one of plaintiffs' experts." *Plata* Br. 53.

For instance, plaintiffs failed to present evidence specifying the conditions at particular facilities, the causes of those conditions, or what particular remedies would be necessary. See, *e.g.*, JA 2117 (expert opinion was based on visits to only eight of 33 prisons); *id.* at 2122-25, 2127 (lack of familiarity with care at particular institutions); *id.* at 2155 (expert only visited one institution but did not evaluate its care); *id.* at 2179 (expert issued reports without visiting the prisons).

Moreover, the OIG reports—upon which appellees otherwise rely, see *Plata* Br. 14, 37—have long showed variable conditions across the system. Although the Receiver's Turnaround Plan is still being implemented, multiple facilities have already reached levels of "moderate adherence" (75% or greater) overall to the Receiver's policies and procedures, as well as "high adherence" (85% or greater) on key individual measures.[16] Moreover, the population of the three facilities referenced in note 16 ranged between 177.9% and 193% of design capacity at the time of the order on appeal. *Monthly Report of Population* at 2; see also Opening Br. 42-43 (explaining meaning of "design capacity" in California system). This demonstrates both that the cap lacks the requisite nexus to the prison conditions that exist systemwide, and that crowding is not closely related to (let alone "primarily causing") Eighth Amendment violations.

5. Among the legal deficiencies of the 137.5% figure is its overbreadth. See Opening Br. 49-52; see also Tr. 2915:16-2916:2 (Judge Karlton expressing concern about "protecting [only] the class members. And maybe that's the appropriate thing to do. ... But it would be ... difficult for me to say [']Yes, and the hell with everybody else.[']").

In response, appellees rely upon the district court's assertion that the relief ordered is the "narrowest ruling possible" because it gives the State "flexibility" to determine how to implement the systemwide population cap. *Plata* Br. 55-56; see *Coleman* Br. 57-58; *accord* JS2-App. 3a. That reliance is misplaced.

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[16] *See, e.g.*, Office of the Inspector General ("OIG"), *Central California Women's Facility: Medical Inspection Results* 1-2 (Apr. 2009) (77.9% overall score, with high adherence scores for urgent services, staffing, pharmacy services and other categories, and scores above 80% for health screening, emergency services, and diagnostic services); OIG, *Valley State Prison for Women: Medical Inspection Results* 1-2 (May 2010) (80% overall score and high adherence scores on emergency services, health screening, pharmacy services, staffing and other benchmarks); OIG, *California Institution for Men: Medical Inspection Results* 1-2 (Oct. 2010) (81.4% overall score and numerous individual high adherence scores).

First, granting a defendant some leeway in implementing sweeping relief does not insulate an overbroad injunction from review. Rather, as one PLRA sponsor explained, a population cap is "the most pernicious form of judicial micromanagement." 141 Cong. Rec. S14407, 14414 (daily ed. Sept. 27, 1995) (Sen. Dole). Put differently, a court ordering a population cap is necessarily micromanaging prison operations.

Under the PLRA and this Court's precedents, injunctive relief must be narrowly tailored to remedy the specific violations found. 18 U.S.C. § 3626(a)(1)(A); *Miller* v. *French*, 530 U.S. 327, 347 (2000) (injunction under the PLRA must be "precisely tailored"). And such relief must respect the states' interests in operating their prisons without excessive judicial meddling. See, *e.g.*, *Lewis* v. *Casey*, 518 U.S. 343, 362-63 (1996); *Chapman*, 452 U.S. at 351-52. A court cannot deprive a state of flexibility in remedying constitutional violations separate from crowding by capping the state's prison population unless doing so is both the only way to achieve constitutional compliance and a direct, focused response to those violations. See, *e.g.*, *Jenkins*, 515 U.S. at 90-92, 97-98; *Dayton Bd. of Educ.* v. *Brinkman*, 433 U.S. 406, 410, 417 (1977) (noting the "vital national tradition" of local autonomy while holding that a systemwide remedy was not "tailor[ed] commensurate to the ... specific violations"); *Occoquan*, 844 F.2d at 835 n.14 (rejecting claim "that a population cap represented a less intrusive remedy than a more detailed order").

Neither appellees nor the courts can avoid the requirement that a prisoner release order be narrowly tailored by giving defendants discretion as to the precise manner in which they implement the mandatory population reduction.

Second, appellees' claim that the State has flexibility is mistaken. A population cap "directly implicates decisions with which the political process is charged," including "how many prisons to build and how large to build them," and which convicts to house in them. *Occoquan*, 844 F.2d at 842-43; *accord Chapman*, 452 U.S. at 350-51 & nn.15-16. Here, moreover, appellees deny reality by suggesting that the order on appeal is not accurately viewed as a "prisoner release order" because "the court left it to the State to determine whether the population should be reduced at all." *Plata* Br. 56; see also *id.* at 58; *Coleman* Br. 32. A population cap undoubtedly constitutes a "prisoner release order." *E.g.*, JS2-App. 2a; 18 U.S.C. § 3626(g)(4). All parties and the district court recognized that true population reduction would occur, Tr. 2988:8 (Judge Reinhardt: "We'll not be building prisons."); JS1-App. 195a-196a ("plaintiffs' ... proposed population reduction measures" included "early release"); and the proposal that the State submitted under duress had to include outright release to satisfy the court's requirements. JS2-App. 26a, 32a, 63a-64a, 68a-70a.

Put simply, the State cannot implement a systemwide 137.5% cap without reductions across CDCR's facilities. Thus, the State must reduce the population of high-performing facilities that are likely meeting the requirements of the Eighth Amendment despite crowding. See *supra* at 35 n.16. As a practical matter, the State lacks flexibility; it must reduce its population without regard to whether those reductions correspond to improvements in the particular facility's constitutional compliance.

Indeed, because the population cap is permanent, see JS2-App. 6a, the State will have little room to maneuver for the foreseeable future. See *Jenkins*, 515 U.S. at 99 (discussing problems with open-ended relief); 141 Cong. Rec. at S14419 (Sen. Abraham) (expressing concern about open-ended injunctive relief resulting from consent decrees). Those repercussions may be profound. See Tr. 2889:1-3 (Judge Karlton: "[T]he reality [is] that if we release people, it will have a very profound effect ... upon the counties' ability to function."); *id.* at 2887:21-23 (same).

Each time the State must refuse prisoners whose incarceration would push the population over the cap, its social safety net will be strained and the additional burden will fall on already overwhelmed local correctional facilities and community services. With any significant increase in crime, the State's lack of flexibility could have significant public safety effects because inmates that California decided to confine will have nowhere to go. Indeed, despite appellees' reliance on the Governor's Emergency Proclamation, *Plata* Br. 4-6; *Coleman* Br. 1, they ignore its most relevant provisions. The proclamation recognizes that the State's local jails are overcrowded, that 20 of 58 counties operate under court-imposed population caps, and that "[m]ost of California's jail population consists of felony inmates, but when county jails are full, someone in custody must be released before a new inmate can be admitted." JA 1703-04, *reproduced in Coleman* Br., App-21.

Finally, the *Coleman* appellees' attempt (at 57) to portray the facility-specific cap Judge Karlton imposed as moot is baseless and conflicts with appellees' longstanding position that certain facilities' populations must be subject to lower caps than the systemwide cap imposed. See Tr. 2915:12-15 ("we are urging 130 percent ... system-wide, but that the specialized programs have to be below their percentage."). In sum, there is far less flexibility than appellees suggest.

6. CCPOA urges this Court not to address the tailoring issues presented here because the three-judge court might revisit the remedy and tether it to the alleged Eighth Amendment violations. Br. 59. This suggestion, while revealing, lacks any basis in the record or in current circumstances in the trial courts. Instead, it is discredited by the actions of the three-judge court, which:

> (1) *sua sponte* sought to cure appellees' deficient case for a 130% cap by ordering a quasi-legislative compromise at 137.5%, *supra* at 32;
>
> (2) invited plaintiffs to "ask this court to impose a lower cap," JS1-App. 184a, and;
>
> (3) intimated that a population cap "at or near only 100% design capacity" ultimately may be required, *id.* at 176a, despite this Court's clear holding that double-celling is not a constitutional violation. *Chapman*, 452 U.S. at 347-51.[17]

---

[17] Indeed, without explaining its nexus to constitutional violations, CCPOA argues that a 90% cap may be necessary. Br. 53; *id.* at 54 (invoking an expert's claim that a "*5% vacancy rate is necessary* to providing adequate care") (emphasis added); *cf. Coleman* Br. 55 (erroneously claiming "'design capacity' and "double-celling" are distractions" here).

B. The Court's Order Does Not Give "Substantial Weight" To Adverse Impacts On Public Safety.

The three-judge prisoner release order failed to give "substantial weight to an adverse impact on public safety," 18 U.S.C. § 3626(a)(1)(A). Appellees' contrary contentions do not cure this serious deficiency. See Opening Br. 53-54; Def.-Intervenors' Br. 21-28; *Amici* Louisiana et al. Br. 23-33.

First, appellees and the district court are wrong to suggest that it is the State's burden to show that population reduction cannot be accomplished safely. See JS2-App. 4a; *Coleman* Br. 59 (suggesting the State had to "bring forth ... evidence" showing a lack of safety). The PLRA's "public safety" requirement is one specific component of plaintiffs' burden to demonstrate that the traditional balance of the hardships and public interest requirements favors issuance of the relief requested. See *Monsanto Co.* v. *Geertson Seed Farms*, 130 S. Ct. 2743, 2756 (2010).

Second, the court compelled the State to propose reduction measures, which the State *did show* would implicate significant public safety concerns. See *supra* at 37-38. To prevent increased crime under the court-mandated population reduction measures, the State would be required to make a substantial investment in "evidence-based rehabilitation programming," JS1-App. 241a-248a—"*i.e.*, programs that research has proven to be effective in reducing recidivism," *id.* at 214a; see *id.* at 200a; see *Plata* D.E. 1708, ¶¶ 135-136 (plaintiffs' expert's reliance on the alleged availability of mental health rehabilitation programs to prevent re-offense, while stating these "programs are currently underfunded"); *id.* ¶¶ 141-145 (outlining "improvements the State should make to its provision of care for mentally ill inmates released to parole"). Appellees' *amici*'s lengthy discussion of such programs strongly suggests their necessity. See, *e.g.*, Br. of *Amici* Center on the Administration of Criminal Law et al. 2, 6-7, 29, 33; ABA Br. 9, 13, 14-16; Corrections & Law Enforcement Personnel Br. 31.

Nonetheless, appellees suggest that if the court did not specifically order those investments (even if they are necessary to guarantee safety) and if the State were theoretically capable of making them, the order satisfies the PLRA. Their view is that the State is to blame if it fails to implement programs necessary to ensure safety. *Plata* D.E. 1766, at 5 (the lack of rehabilitation programs should not concern the court because it "is the state's responsibility to provide funding for such programs, and it is the state's failure to do so that has caused this dearth of programs"); Tr. 2892:4-2894:17 (appellees' counsel: "I personally think [providing additional funding] would be a rational thing to do if the State is concerned about public safety."); *id.* at 2909-2911. In fact, when Congress required a three-judge court to give "substantial weight" to "any adverse impact on public safety," 18 U.S.C. § 3626(a)(1)(A), it plainly did not intend the Court to make the determination in a theoretical world.

Third, appellees acknowledge that no matter what investments are made, individuals will commit crimes during the period they otherwise would have been in prison. See JS1-App. 201a. Appellees and the district court minimize these effects by claiming that early release "affects only the timing and the circumstances of the crime ... committed by a released inmate—*i.e.*, whether it happens a few months earlier or a few months later." *Id.* That odd argument rests on the false premise that time in prison and the aging of the prisoner have no effect on recidivism. But see Tr. 1474:1-6, 3122:8-3124:7 (recidivism risk falls as inmates age); CDCR, *2010 Adult Institutions Outcome Evaluation Report* 15 & fig.6 (Oct. 11, 2010) (same).

In all events, this fatalism is irrelevant to the victims of crime and inconsistent with the PLRA, which asks whether the *prisoner release order* will affect public safety, not whether release of an inmate at any point will do so. See Opening Br. 53; *Amici* Louisiana et al. Br. 27-32; 141 Cong. Rec. at S14418 (Sen. Hatch) (stating that caps lead to "vicious crimes committed by individuals who should have been locked up"); 141 Cong. Rec. S2648, S2649 (daily ed. Feb. 14, 1995) (Sen. Hutchison) (absent population caps, "we could [imprison] people who ... would not be going out on the streets of Texas murdering, raping, and injuring the people of my State"); see also *Samson* v. *California*, 547 U.S. 843, 854 (2006) ("parolees ... are most likely to commit future criminal offenses"); cf. JS1-App. 201a.

CONCLUSION

For these reasons and those stated in the opening brief, the Court should reverse the judgment for lack of jurisdiction and dismiss the three-judge court. In the alternative, the Court should reverse the judgment of the district court.

Respectfully submitted,

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REPLY
BRIEF

No. 09-1233

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IN THE

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GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from an Order of the Three-Judge Court in the United States District Courts for the Northern District of California and the Eastern District of California

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RESPONSE OF INTERVENORS

INTRODUCTION

The Prisoner Release Order issued below poses a grave and immediate threat to public safety in the State of California by requiring the release or non-incarceration of tens of thousands of California prisoners over the next two years To protect the ability of states to operate and maintain their own criminal justice systems and to protect public safety, Congress enacted the Prison Litigation Reform Act, 18 U.S.C § 3626 ("PLRA") Congress acted to ensure that such prisoner release orders could be made only as a remedy of last resort and designed three primary protections against improvident prisoner release orders into the PLRA.

First, Congress required that a three-judge court issue a prisoner release order only if plaintiffs prove, by clear and convincing evidence, that "(i) crowding is the primary cause of the violation of the Federal right;" and "(ii) no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E). In doing so, Congress employed the present tense for its "primary cause" analysis and, accordingly, required that three-judge courts make a determination regarding the relationship between current violations of a Federal right, if any, and crowding. The court below violated the PLRA by not only refusing to make a determination regarding the existence and scope of current violations, if any, but also by barring Appellant-Intervenors from providing evidence and argument on the issue. The court below committed further error by finding that "no other relief will remedy the violation of the Federal right" notwithstanding viable alternative remedies

Second, Congress mandated that a prisoner release order be issued only if such order "is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3826(a)(1)(A). The court below erred by issuing a sweeping prisoner release order that is not targeted at the remediation of current violations of federal law, if any, and would effectuate the release or non-incarceration of tens of thousands of non-class member inmates.

Third, Congress also required that a court contemplating a prisoner release order give "substantial weight" to any adverse impact on public safety or the operation of a criminal justice system. 18 U.S C. § 3626(a)(1)(A). The court below erred because it not only failed accord "substantial weight" to adverse impacts on public safety and the operation of a criminal justice system, it declined explicitly to evaluate the individual elements of the Prisoner Release Order that it ultimately issued for their impact on public safety. The result is an order that both violates the PLRA and affirmatively threatens public safety in California.

Appellees' primary response is to dodge these critical issues of statutory interpretation and application and to focus instead on untimely and inapplicable evidence and arguments regarding past conditions in the California prison system. Worse still, Appellees also offer a series of erroneous assertions regarding the current state of the California prisons in a desperate attempt to justify the release of tens of thousands of inmates notwithstanding the refusal of the court below to make a finding regarding what current violations of federal law, if any, existed at the time of trial. For example, Appellees claim that prisoners are dying unnecessarily at the rate of one every eight days This assertion is simply not accurate. In reality, the very document cited by Appellees places the number of "likely preventable" deaths for the entire year of 2009 at 3. *See* California Prison Receivership, Analysis of Year 2009 Death Reviews (Sept. 2010), *available at* http://www.cphcs.ca.gov/docs/resources/ORTES_DeathReviewAnalysisYear2009_20100907.pdf. Accordingly, even crediting Appellees' assertion with the benefit of "likely" preventable results – as opposed to proven results – the statistics show, at most, one unnecessary death every four months, not one every eight days.

Similarly, Appellees assert that "the prisons are about as crowded now as they were when the Governor first proclaimed the State of Emergency, which continues to the day." *Plata* Brief at 2-3.[1] Not so. In reality, from October 2006 to October 2010 the population of the 33 adult facility prisons in California has decreased by 14,832 inmates. *See* California Department of Corrections and Rehabilitation, Monthly Population Report, *available at* http://www.cdcr.ca.gov/reports_research/offender_information_services_Branch/monthly/TPOP1A/TPOP1Ad1010.pdf. This decrease has been achieved largely through the transfer of inmates to out-of-state facilities and it belies Appellees' assertion of a current "crisis" with respect to medical and mental health care in the California prisons caused by overcrowding.

Finally, Appellees fail to provide a meaningful response to the public safety concerns raised by issuance of the Prisoner Release Order. This failure to respond is particularly troubling in light of the candid admission of the court below that "we have not evaluated the public safety impact of each element of the State's proposed plan." JS2-App. 3a Had the requisite "substantial weight" been given to the adverse impact that this Prisoner Release Order would have on public safety and the operation of the criminal justice system in California, it would never have been issued.

In sum, no volume of references to past conditions or to the Governor's 2006 emergency proclamation can justify the Prisoner Release Order issued here in light of the current conditions in the California prisons, the evidence presented at trial and the strict limitations on prisoner release orders imposed by Congress in the PLRA.

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[1] The merits briefs of the *Plata* and *Coleman* Appellees are referred to respectively as the "*Plata* Brief" or "*Coleman* Brief"

I. MEDICAL AND MENTAL HEALTH CARE IN THE CALIFORNIA PRISON SYSTEM MUST BE CONSIDERED IN CONTEXT

The court below and Appellees suggest that California has an atypical and unusual penal system, characterizing the State's penal laws as "inflexible" and "harsh" and the increase in prison population as "massive." *See* JS1-App. 254a However, in many ways, California has a very typical prison system compared to other states In 2008, the last year for which comparative state incarceration rates are currently available, California had the 17th highest incarceration rate (467 per 100,000 residents, only slightly higher than the national average or 445 per 100,000 residents).[2] Significantly, California was one of only twelve states whose incarceration rate fell between 2000 and 2007,[3] and California also experienced the largest decrease in inmate population of any state in 2008-2009.[4] California ranks 16th among the states in terms of the state prison population as a percentage of highest capacity, according to 2008 federal statistics.[5] California does not, on average, impose particularly long sentences by national standards either.[6] In the fourth quarter of 2008, the average sentence imposed was 49 months and the average sentence served was 24.9 months in California [7]

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[2] Congressional Quarterly, CRIME STATE RANKINGS 2010, Congressional Quarterly (2010) at p 54, the original source data is United States Department of Justice, Bureau of Justice Statistics, "Prisoners in 2008," (December 2009), *available at* http://bjs ojp usdoj gov/content/pub/pdf/p08 pdf

[3] United States Department of Justice, Bureau of Justice Statistics, "Prisoners in 2007," (December 2008), *available at* http //bjs ojp usdoj gov/content/pub/pdf/p07 pdf

[4] Pew Center on the States, "Prison Count 2010" (April, 2010), *available at* http://www.pewcenteronthestates org/uploadedFiles/Prison_Count_2010 pdf?n=880

[5] *Id*

Similarly, California's medical outcomes are in the mainstream when compared to those in other states. Indeed, federal studies demonstrate that state prison inmates experience a lower mortality rate than the comparable age cohort of the public at large[8] and that California inmates have consistently had lower mortality rates than inmates in most other state prison systems.[9] In a recent six year federal study, the composite mortality rate for California prison inmates was lower than inmate mortality in 37 other states.[10] In contrast, the Pennsylvania state prison system, which produced two of the expert witnesses upon whom the court below and Appellees rely, produced the second highest inmate mortality rate among the 50 states.[11]

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[6] Joan Petersilia, "Understanding California Corrections," University of California, California Policy Research Center (May 2006) at pp 7-8, *available at* http //ucicorrections seweb uci edu/pdf/understandingcorrectionspetersilia20061 pdf

[7] California Department of Corrections and Rehabilitation, Fourth Quarter 2008 Facts and Figures, *available at* http // www cdcr ca gov/Divisions_Boards/Adult_Operations/docs/Fourth _Quarter _2008_Facts_and_Figures pdf

[8] United States Department of Justice, Bureau of Justice Statistics, Christopher J Mumola, "Brief Medical Causes of Death in State Prisons 2001-2004," (January 2007), *available at* http //bjs ojp usdoj gov/context/pub/pdf/mcdsp04 pdf This report reflects an average citizen mortality rate of 308 per 100,000 and an inmate mortality rate of 250 per 100,000 per year This phenomenon is summarized in a U S Department of Justice press release entitled "Death Rates Lower in State Prisons Than in the General Population," United States Department of Justice, Office of Justice Programs, January 21, 2007, *available at* http//www ojp usdoj gov/newsroom/pressreleases/2007/BJS07010 htm

[9] U S Department of Justice, Bureau of Justice Statistics, "State Prison Deaths 2001-2009," (Table 7) (2010)

Finally, California spends a disproportionately high amount per prisoner on medical and mental health care and, in addition, has significantly expanded staffing and expenditures for inmate healthcare, nearly doubling per inmate funding under the federal Receivership.[12] Most recently, the Receiver spent $1.8 billion in fiscal year 2008-09 to provide medical care to the inmate population.[13]

II. THE PRISONER RELEASE ORDER SHOULD NOT HAVE ISSUED BECAUSE THERE WAS NO DETERMINATION THAT PAST VIOLATIONS WERE CURRENT AND ONGOING AND BECAUSE ALTERNATIVE REMEDIES EXISTED

Under the PLRA, a three-judge court "shall enter a prisoner release order only if the court finds by clear and convincing evidence that – (i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E) The Prisoner Release Order issued below failed to meet either of these requirements.

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[10] *See id*

[11] *See id*

[12] *Plata* D E 1632 ¶¶ 7-9, *see also* Trial Tr (Todd Jerue, Program Budget Manager, California Dept of Finance) 734 13-736 25 (E D Cal /N D Cal Nov 21, 2008) *Plata* D E 1845

[13] Office of the Inspector General, California Prison Health Care Receivership Corporation Use of State Funds for Fiscal Year 2008-09, at 1 (June 2010), *available at* http //documents reportingtransparency ca gov/Common/Document ashx?ID=6384 &TB_iframe=true

First, the PLRA is written in the present tense and permits issuance of prospective prisoner release orders only to correct current and ongoing violations of Federal rights. Notwithstanding this mandate, the three-judge court refused to determine whether past violations remained "current and ongoing" at the time of the trial, and did not identify any specific ongoing violations. JS1-App. 78a n.42; *see also* JS1-App. 77a. The assumption by the three-judge court that "the previously identified constitutional violations" were ongoing contravenes the PLRA. JS1-App. 77a. It is no answer to this argument to assert, as Appellees do, that (1) Appellees need not "re-litigate" the issue of "liability", (2) the State defendants have conceded constitutional violations of varying degrees both before and after the three judge court was convened, or (3) "[t]he State does not point to any evidence that was excluded, which demonstrates that there was no error and no prejudice." *Plata* Brief at 33-37; *Coleman* Brief at 33-35.

Appellees assert incorrectly that Appellant-Intervenors seek an interpretation of the PLRA that would require three-judge courts to "re-determine liability" or "re-litigate the existence of the underlying constitutional violations." *Plata* Brief at 33; *Coleman* Brief at 33. Not so. Prior single judge liability determinations made in the past remain in place as they relate to conditions as they existed at that time. However, it cannot be said that requiring the three-judge court to determine whether current violations exist constitutes the "re-litigation" of liability determinations made in the past For example, requiring the three-judge court here to determine what current violations of federal law, if any, existed at the time of issuance of the Prisoner Release Order could not possibly constitute re-litigation of the single judge determinations because those initial determinations were made long before based on conditions then in existence. Moreover, it is contrary to both the plain text and the purpose of the PLRA for a three-judge court to simply assume that the prior determinations of a single judge court regarding conditions as they existed years earlier remain valid years later and to issue a prisoner release order on that basis because the PLRA is written in the present tense and requires a determination of whether crowding "is" – not "was" – the primary cause of violation of the Federal right. 18 U S C § 3626(a)(3)(E).

Nor does any concession by the State preclude the Appellant-Intervenors from raising, and the Court from enforcing, the obligation of the three-judge court under the PLRA to determine what, if any, constitutional violations existed at the time of trial. This is true because the PLRA specifically grants the Appellant-Intervenors the ability to intervene as of right in this proceeding based on the recognition by Congress that the statutory intervenors play a crucial role in protecting public safety and have a legitimate interest in opposing issuance of a prisoner release order independent of positions adopted by the State. Moreover, the primary concession cited by Appellees is the Governor's 2006 proclamation, which was years old by the time of trial and, accordingly, did not address current conditions at the time that the court below made its primary cause determination. The undisputed fact is that the 2006 proclamation found overcrowding based on the then-current fact that the California prison system exceeded its operational capacity by approximately 15,000 inmates.[14] As discussed previously, prison population within California's 33 adult facility prisons has decreased by 14,832 inmates since the month the proclamation was issued. Accordingly, while the population still exceeds "design capacity" under California's unique one-prisoner-per-cell definition, the population within the 33 adult prisons is now very close to its "operational capacity."

Nor can Appellees assert that there is "no evidence that was excluded" below. *Plata* Brief at 36. Appellant-Intervenors specifically requested from the three-judge court a determination of what constitutional violations, if any, remained at the time of trial and offered to present evidence and argument that there were no such ongoing violations. The request and the offer of Appellant-Intervenors were vehemently refused by the three-judge court. Trial Tr at 57:11-58:13 (E.D. Cal./N.D. Cal. Nov. 18, 2008) (*Coleman* D.E. 3541.2, *Plata* D.E. 1829) ("Twice this court has said we will not receive that *evidence* [of the absence of current constitutional violations]. (emphasis added). You have made as clear a record as you can."); DJA Vol. VI 2081-2087.[16]

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[14] As acknowledged by the three-judge court, there is a significant difference between "operational capacity" and "design capacity" and California employs an atypical definition of the term "design capacity." The court cited to Plaintiffs' Exhibit 4 at page 123 (DJA Vol. V at 1760-61):

> "Design capacity" is the term used for the past 50 years to designate the number of inmates a prison is designed to accommodate according to standards developed by the Commission on Accreditation and the American Correctional Association. [Footnote omitted.] The number can be based on any combination of single-occupancy cells, double-occupancy cells, single- or double-bunked multiple occupancy rooms, or dormitories. The standards take into account the need for humane conditions, as well as the need to prevent violence and move inmates to and from programs, such as mental health care, education classes, and drug abuse treatment.
>
> *In California, design capacity is based on one inmate per cell, single bunks in dormitories, and no beds in space not designed for housing.*

JS1-App. 56a-57a (emphasis added).

Second, a prisoner release order may issue only if a plaintiff demonstrates – by clear and convincing evidence – that "no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E). Here, the three-judge court's conclusion that no other alternatives to the Prisoner Release Order existed is belied by the court-appointed *Plata* Receiver who stated that, under his control, the California prison systems would not have any "difficulty in providing medical services [to the entire prison population] no matter what the population is." Trial Declaration of Assemblymember Todd Spitzer, ¶ 28 and Exhibit D thereto, at 30:00 minutes and 31:20 minutes (E.D. Cal./N.D. Cal. Oct. 30, 2008) (*Coleman* D.E. 3173; *Plata* D.E. 1656); DJA Vol. IV 1222-1236. Contemporaneous to the trial, the Receiver also stated "there is genuine reason for some hope that CDCR's health care system can be fixed, and that the Receiver is the right instrument for completing the fix in a reasonable period of time and at a reasonable cost." Ninth Quarterly Report of the Federal Receiver's Turnaround Plan of Action (Sept. 15, 2008) at DJA Vol. III 1209. Appellees fail to come to terms with this crucial evidence and try to minimize its importance because it was not made via live testimony in the course of the trial below. *Plata* Brief at 36 n. 8. However, the parties were limited to such "out-of-court" evidence from the Receiver because the three-judge court refused to permit discovery on the Receiver and refused to have him testify in court. *See* Protective Order re Deposition of Receiver (E.D. Cal./N.D. Cal. Nov. 29, 2007) (*Coleman* D.E. 2577; *Plata* D.E. 988). Nothing in the three-judge court's opinion or the Appellees arguments reconciles the issuance of the Prisoner Release Order with the uncontroverted evidence adduced from the Receiver that no such order is necessary and that alternatives exist.[16]

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[16] Had Appellant-Intervenors been given the opportunity, they would have presented compelling testimony, evidence and argument regarding the absence of current violations. Given the clear focus of the PLRA in guaranteeing that prisoner release orders remain a remedy of last resort for addressing current and ongoing violations of a Federal right, the Prisoner Release Order below should be reversed and Appellants should be given the opportunity to demonstrate the absence of current violations.

Congress intended a prisoner release order be "the remedy of last resort." H.R. Rep. No. 104-21, at 25 (1995). The court below erred by issuing the Prisoner Release Order here notwithstanding viable, promising alternatives that are currently underway including, but not limited to, the continued work of the Court-appointed Receiver and Special Master and the ongoing transfer of inmates to out-of-state facilities.[17] Appellant-Intervenors also presented evidence of additional alternatives at trial.[18] Accordingly, the Prisoner Release Order fails to comply with the PLRA's requirement that such release orders may be issued only when "no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E).

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[16] It is also significant that while the Receiver has filed his own brief in this action, he never asserts that his statements made regarding the ability to provide constitutional levels of care "no matter what the population is" offered into evidence during the trial below were incorrect or that no alternative to the Prisoner Release Order exists. Presumably, if the Receiver believed that the Prisoner Release Order issued below were necessary and appropriate, he would have filed his brief in support of Appellees and stated such a conclusion plainly. Since he did not do so, it is entirely appropriate to conclude that the Receiver believed his statements were true when made and remain true.

III. THE PRISONER RELEASE ORDER FAILS TO SATISFY THE PLRA'S REQUIREMENT THAT ANY SUCH RELIEF BE BOTH NARROWLY DRAWN AND THE LEAST INTRUSIVE MEANS TO REMEDY VIOLATION OF THE FEDERAL RIGHT

Any prisoner release order issued pursuant to the PLRA is valid only if the order "is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3826(a)(1)(A). For two reasons, the Prisoner Release Order does not satisfy the requirement mandated by Congress.

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[17] California continues to contract for additional transfer of inmates. *See, e.g.*, http://cdcrtoday.blogspot.com/2010/11/cdcr-enters-contract-with-geo-group-inc.html

[18] Additional potential alternatives to the Prisoner Release Order include: (1) ordering additional hiring of medical staff and allocation of treatment space and mental health beds, (2) expedited construction pursuant to AB 900 facilitated by court waivers of state law, and (3) ordering the federal prison system to take custody of California inmates who are subject to deportation.

First, the court below refused to determine whether previously-identified constitutional violations still existed at the time of trial and, if so, the current scope of such violations. Trial Tr. at 57:11-58:13 (E.D. Cal./N D. Cal. Nov. 18, 2008) (*Coleman* D.E 3541.2; *Plata* D.E. 1829) ("Twice this court has said we will not receive that evidence [of the absence of current constitutional violations]. You have made as clear a record as you can."), DJA Vol VI 2081-2087. Nor did the three-judge court endeavor to determine which, if any, of the 33 facilities within the California prison system currently fail to provide constitutional levels of care. *Id.* The result is an overbroad and overreaching system-wide release order that fails to adequately identify or correct a present violation of the Federal rights of "a particular plaintiff or plaintiffs." *See Hines v. Anderson*, 547 F.3d 915, 922 (8th Cir. 2008) (affirming dismissal of an order under the PLRA that was not tailored to the specific violation at issue because it addressed medical conditions generally rather than "a particular medical issue that existed at the time."). Neither the court below, nor Appellees, adequately identify what current violations existed at which California prison facilities at the time of trial, much less how this unprecedented system-wide Prisoner Release Order is narrowly-tailored to any particular medical issue.

Second, under the PLRA, a narrowly-tailored prisoner release order would not simply reduce the overall prison population but would instead focus directly and exclusively on medical and mental health treatment issues such as staffing ratios, equipment and facilities, and record-keeping. In addition, this approach is consistent with the position of the Receiver who claimed an ability to provide constitutional care "no matter what the population is." Spitzer Trial Decl., *supra*, ¶ 28 and Exhibit D, at 30:00 minutes (E.D. Cal./N.D. Cal. Oct. 30, 2008) (*Coleman* D.E. 3173; *Plata* D.E. 1656); *see also id.* at 31.20 minutes ("We believe we can provide constitutional levels of care no matter what the population is."); DJA Vol. IV 1222-1236

In response, Appellees make no real effort to demonstrate that the Prisoner Release Order is narrowly-tailored. Instead, they rely on the fact the State has been given a level of discretion with respect to how the population will be reduced and which prisoners will be released. *Plata* Brief at 55-56; *Coleman* Brief at 54. This argument is particularly unpersuasive given that the Prisoner Release Order, as issued, will indisputably impact -- and directly benefit -- thousands of inmates that are not even members of the plaintiff classes and because the court below rejected the State's initial plan which contemplated population reduction over a five-year period.

IV. THE PRISONER RELEASE ORDER VIOLATES THE PLRA BECAUSE IT NOT ONLY FAILS TO GIVE SUBSTANTIAL WEIGHT TO ANY ADVERSE IMPACT ON PUBLIC SAFETY, IT AFFIRMATIVELY THREATENS PUBLIC SAFETY

The PLRA requires any three-judge court contemplating issuance of a prisoner release order to give "substantial weight" to any adverse impact on public safety or the operation of a criminal justice system. 18 U.S.C. § 3626(a)(1)(A). The three-judge court's disregard of this requirement threatens the safety of millions of California citizens and violates the PLRA.

Although the court below acknowledged that Congress intended release orders as "the remedy of last resort," the three-judge court (and Appellees) failed to properly consider the impact that the release of tens of thousands of prisoners will have on public safety in California Instead, the three-judge court, without record support, asserted "that means exist by which the defendants can accomplish the necessary [release of approximately 46,000 prisoners] without creating an adverse impact on public safety or the operation of the criminal justice system." JS2-App. 2a.

As a preliminary matter, the conclusion of the three-judge court regarding the possibility of a 46,000 inmate release being implemented without an adverse impact on public safety is impossible to reconcile with the undisputed trial testimony that California has an approximately 70% recidivism rate and that research shows that each inmate commits approximately 12 crimes before being apprehended, tried, convicted and sentenced to state prison. *See* Trial Tr (Police Chief Jerry Dyer) 2315 04-2318:20 (E.D Cal /N.D. Cal. Dec. 12, 2008) *Coleman* D E. 3541.13; *Plata* D.E. 1939, DJA Vol VI 2526-28.

Moreover, this Court has never defined what a three-judge court must do in order to comply with the PLRA's requirement that "substantial weight" be given to any adverse impacts on public safety and the criminal justice system. If the requirement means anything, it must require, at a minimum, the three-judge court to evaluate carefully the impact each element of a proposed release order would likely have on public safety. In this case, the three-judge court admits it has not done so and instead confirms the opposite: "we have not evaluated the public safety impact of each element of the State's proposed plan." JS2-App 3a In addition to not evaluating the individual elements of the implementation plan for the Prisoner Release Order, the three-judge court also emphasizes that, "we are not endorsing or ordering the implementation of any of the specific measures contained in the State's plan, only that the State reduce the prison population to the extent and at the times designated in this Order." JS2-App. 5a. This approach fails to give substantial weight to public safety and, therefore, violates the PLRA.

Finally, the three-judge court acknowledges concerns regarding implementation of its order and funding of programs necessary to promote public safety, but its Prison Release Order includes no provision whatsoever designed to ensure public safety Instead, the three-judge court holds that the State, rather than the Court, should evaluate whether counties will need additional funding to ensure that the Prisoner Release Order does not jeopardize public safety.[19] Most significantly, the Prisoner Release Order lacks any provision whatsoever to account for the return to California communities of the approximately 46,000 prisoners to be released. In sum, the three-judge court's failure to give any weight, let alone substantial weight, to public safety prior to issuing the Prisoner Release Order is contrary to the PLRA

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[19] The three-judge court observes that "Counties may well require additional financial resources from the State in order to ensure that no significant adverse public safety impact results from the State's population reduction measures" JS2-App 5a But the three-judge court refuses to address that issue and instead leaves it to the State, stating, "whether public safety requires such a reallocation demands serious consideration by the State, both under its general responsibilities to the public and in accord with the PLRA" *Id* However, it is the three-judge court – not the State of California – that has a responsibility to ensure that any prisoner release order is in accord with the PLRA

In response, Appellees offer a series of evasions First, Appellees claim that the court below did not disregard public safety because "[t]he court examined hundreds of exhibits related to public safety and devoted nearly ten days of trial " *Coleman* Brief at 58. But, regardless of how many exhibits were submitted, the fact remains that the court below admits, "we have not evaluated the public safety impact of each element of the State's proposed plan." JS2-App. 3a. Also, the court below issued a Prisoner Release Order which, on its face, contains no provisions for the protection of public safety. This too, is far more important than how many exhibits were submitted or how long trial lasted. Next, and contrary to their above position, Appellees assert that the State failed to "bring forth any evidence below of the public safety concerns it now emphasizes " *Coleman* Brief at 59 Even if Appellees were correct about the evidence presented by the State, which they are not, Appellees ignore entirely the compelling evidence presented by the Appellant-Intervenors regarding the very real threat this Prisoner Release Order poses to public safety and the operation of California's criminal justice system. *See, e.g* , Trial Tr. (Dep. District Attorney Lisa Rodriguez) 978-1016 (E D. Cal./N.D. Cal. Dec. 2, 2008) *Plata* D E. 1877; Trial Tr. (Chief Probation Officer Jerry Powers) 1017-1060 (E.D. Cal./N.D. Cal Dec 2, 2008) *Plata* D.E. 1877; Trial Tr (Chief Probation Officer Jerry Powers) 1144-1191 (E.D. Cal./N.D Cal Dec. 3, 2008) *Plata* D.E. 1879; Trial Tr. (Acting County Executive Gary Graves) 2244-2287 (E.D. Cal./N.D Cal. Dec. 11, 2008) *Plata*

D E. 1935; Trial Tr. (Police Chief Jerry Dyer) 2296-2371 (E.D Cal./N.D. Cal Dec. 12, 2008) *Plata* D.E. 1939; Trial Tr. (District Attorney Rod Pacheco) 2372-2404 (E.D Cal./N.D Cal Dec 12, 2008) *Plata* D.E. 1939; Trial Tr (District Attorney Bonnie Dumanis) 2408-2423 (E.D. Cal./N.D. Cal. Dec. 12, 2008) *Plata* D.E. 1939; Trial Tr. (Nancy Pena, Director of the Menatal Health Department of the Santa Clara Valley Health and Hospital System) 2424-2457 (E.D. Cal./N.D. Cal. Dec. 12, 2008) *Plata* D E. 1939; Trial Tr. (California Assemblyman Todd Spitzer) 2457-2484 (E.D. Cal./N.D Cal. Dec. 12, 2008) *Plata* D.E. 1939; Trial Tr. (Robert Garner, Director of Alcohol and Drug Services, Santa Clara County) 2484-2501 (E.D Cal./N.D. Cal. Dec. 12, 2008) *Plata* D.E. 1939, Trial Tr. (Alexander Yim, Divisional Chief, Los Angeles County Sheriff's Department) 2631-2657 (E.D. Cal./N.D. Cal. Dec. 18, 2008) *Plata* D.E 1969; Trial Tr. (Sheriff Adam Christianson) 2657-2681 (E D. Cal /N D. Cal. Dec. 18, 2008) *Plata* D.E. 1969; Trial Tr (Sheriff Martin Ryan) 2682-2708 (E.D. Cal./N.D. Cal. Dec. 18, 2008) *Plata* D.E 1969, Trial Tr. (California Senator George Runner) 2723-2753 (E.D. Cal./N.D. Cal. Dec. 19, 2008) *Plata* D.E. 1972, Trial Tr. (Chief Probation Officer Donald Meyer) 2753-2794 (E D. Cal /N.D. Cal Dec. 19, 2008) *Plata* D.E 1972 Appellees cannot simply wish away public safety evidence offered by those in the best position to provide it – active law enforcement officers, probation officers, prosecutors and legislators.[20] Nor can Appellees simply assume that there will be no adverse effect on public safety because "[d]ozens of other jurisdictions throughout the country have safely implemented reductions in prison and jail populations without seeing increases in recidivism or crime." *Coleman* Brief at 60; *see Plata* Brief at 58-59. This Prisoner Release Order is unprecedented in size and scope and is made at a time when California has an a multi-billion dollar deficit and lacks the resources to provide the kind of expansive and costly rehabilitative re-entry programs that might soften the devastating impact that this order will have on California communities if permitted to stand. Moreover, Appellees fail entirely to account for California's approximately 70% recidivism rate in comparing this Prisoner Release Order to reductions in populations made elsewhere. With respect to this particular Prisoner Release Order, there is no assurance whatsoever of safe implementation because the court below did not even "evaluate[] the public safety impact of each element of the State's proposed plan" JS2-App. 3a. Nor can Appellees justify the issuance of a prisoner release order as consistent with public safety by reference to "the continuing constitutional violations, resulting from inundated prison facilities" where, as here, the court below fails to make findings regarding

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[20] Appellees also fail to address, much less distinguish, the research findings and scholarly work cited by the Appellant-Intervenors with respect to public safety and the adverse impact the Prisoner Release Order will have on public safety and operation of the criminal justice system in California if not reversed While *Amici*, Center on the Administration of Crimi-

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nal Law and 30 Criminologists, at least address the scholarly literature, the fact remains that the second edition of the authority *Amici* cite, on page 17 footnote 32, from noted expert James Q Wilson underscores the point made by Appellant-Intervenors "We are more confident than we once were that the rate at which offenders are sent to prison, other things being equal, will affect the crime rate The higher the probability of punishment, the lower the crime rate" James Q Wilson, "Crime and Public Policy," in CRIME (James Q Wilson & Joan Petersilia, eds , 2002), at pp 537-538 what current violations, if any, exist at the time the release order is issued. *See Coleman* Brief at 60. Moreover, the Prisoner Release Order will also ironically compromise the health and increase the mortality rate of the inmates themselves An extensive study of inmate mortality, published in the *New England Journal of Medicine*, illustrates starkly that the Prisoner Release Order issued here is likely to have a deadly impact on any released inmates.[21]

None of the assertions offered by Appellees demonstrate that the court below complied with the PLRA's requirement that substantial weight be given to any adverse impact on public safety or the operation of a criminal justice system when it issued this Prisoner Release Order. *See* 18 U.S C. § 3626(a)(1)(A). On the contrary, the record demonstrates that the court below abdicated its responsibility under the PLRA with respect to public safety by failing to evaluate for public safety impact the elements that comprise State's plan to comply with the Prisoner Release Order issued here. The result is an unprecedented, massive prisoner release order that denies the reality that early release and failure to incarcerate tens of thousands of inmates over a two year period in State with a 70% recidivism rate is a recipe for a public safety disaster.[22] This is exacerbated by the fact local California county jails have no capacity to incarcerate additional inmates. Twenty of California's counties, are under court-ordered population caps and another 12 have self-imposed population caps.[23] This total represents over 60% of the jail capacity in the state.[24] Nearly 13,000 jail inmates are currently being released per month due to lack of space.[25] As such, there is no significant excess capacity for county jails to house released state inmates who commit additional crimes or are diverted from state prison.

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[21] Ingrid A Binswanger, M D *et al* , "Release from Prison – A High Risk of Death for Former Inmates," *New England Journal of Medicine*, 356,2, January 11, 2007, *available at* http.// www nejm org/doi/pdf/10 1056/NEJMsa064115 (Finding not only that the mortality rate for former inmates far exceeds that of the general public when controlled for "age, sex and race" but also that "[f]or nearly all causes of death, the rates among former inmates were substantially higher than those among inmates ")

Because the court below failed to give any weight – much less the "substantial weight" required by Congress – to the adverse impact on public safety and operation of a criminal justice system, this Prisoner Release Order violates the PLRA and must be reversed

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[22] Research and evidence presented at trial shows on average that inmates commit on average 12 offenses prior to being apprehended, tried, convicted and sentenced *See* Trial Tr (Police Chief Jerry Dyer) 2315 04-2318 20 (E D Cal /N D Cal Dec 12, 2008) *Coleman* D E 3541 13, *Plata* D E 1939, DJA Vol VI 2526-28

[23] California State Association of Counties, Governor's Proposed 2010-11 Budget Counties Respond," *available at* http // www counties org/images/users/1/CountiesRespondAoJ pdf

[24] California Corrections Standards Authority, Legislative Report – Local Corrections in California, 2008, at 12, *available at* http //www cdcr ca gov/CSA/Admin/Docs/2008_LegislativeReport pdf

[25] California Corrections Standards Authority, Jail Population Survey, First Quarter 2010, *available at* http //www cdcr ca gov/CSA/FSO/Docs/2010_1st_Qtr_JPS_full_report pdf.

CONCLUSION

For all these reasons, the Court should reverse the Prisoner Release Order issued below

Respectfully submitted,

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BRIEF

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In The

Supreme Court of the United States

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GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,

Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, *et al.*,

Appellees.

◆

On Appeal From An Order Of The Three-Judge Court In The United States District Courts For The Northern District Of California And The Eastern District Of California

◆

BRIEF FOR THE AMERICAN BAR ASSOCIATION AS AMICUS CURIAE SUPPORTING APPELLEES AND CORRECTIONAL OFFICER INTERVENORS

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STATEMENT OF INTEREST OF *AMICUS CURIAE*, AMERICAN BAR ASSOCIATION (ABA)[1]

Amicus curiae American Bar Association ("ABA") respectfully submits this brief in support of Appellees and the Correctional Officer Intervenors. Based on its forty-five years of study of prisoner incarceration, release, and recidivism issues, the ABA requests that the Court affirm the lower court's population reduction order.

The ABA is the largest national voluntary membership organization of the legal profession. Its approximately 400,000 members include attorneys in private practice, government service, and public interest organizations, as well as legislators, law professors, and judges.[2] As practitioners and judges, many ABA members strive to make the criminal justice system work efficiently and fairly. Some members represent the government in seeking incarceration, some represent criminal defendants facing incarceration; and some, as judges, decide the sentences of convicted defendants. Other members represent prisoners challenging conditions of their confinement, or counsel penal institutions on legal compliance.

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[1] Pursuant to Rule 37.6, *amicus curiae* certifies that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus*, its members, or its counsel, has made a monetary contribution to the preparation or submission of this brief. The parties have filed their written consent to the filing of *amicus* briefs pursuant to Rule 37.3

[2] Neither this brief nor the decision to file it should be interpreted to reflect the views of any judicial member of the ABA. No member of the ABA Judicial Division Council participated in the preparation of this brief, or in the adoption or endorsement of the positions in this brief.

The ABA began a comprehensive study of the criminal justice system in 1964, under the aegis of then-ABA President (and later Justice) Lewis F. Powell, Jr. When the first full edition of the ABA STANDARDS FOR CRIMINAL JUSTICE was published in seventeen volumes, Chief Justice Warren E. Burger called them "a balanced, practical work intended to walk the fine line between the protection of society and the protection of the constitutional rights of the accused individual." Warren E. Burger, *Introduction: The ABA Standards for Criminal Justice*, 12 AM. CRIM. L. REV. 251, 251-52 (1974).[3]

Today, the ABA continues to develop, refine and publish updated volumes of the Standards.[4] Those concerned with the treatment of prisoners were substantially revised and adopted as ABA policy in February 2010.[5] Participating in this work were prosecutors, defenders, judges, current and former chief administrators and the general counsel of major correctional systems, and liaisons from the American Correctional Association and the U.S. Department of Justice, among others.

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[3] The current Standards and a history of their development are available on the ABA website at http://www.abanet.org/crimjust/standards/home.html. *See also* Martin Marcus, *The Making of the ABA Criminal Justice Standards: Forty Years of Excellence*, 23 CRIM. JUST. 10 (2009), *available at* http://www.abanet.org/crimjust/standards/marcus.pdf.

[4] The Standards become official ABA policy when they are adopted by vote of the ABA House of Delegates. The ABA House of Delegates is composed of more than 500 representatives from states and territories, state and local bar associations, affiliated organizations, ABA sections, divisions and members, and the Attorney General of the United States, among others. *See* ABA General Information, http://www.abanet.org/leadership/delegates.html (last visited Oct. 29, 2010).

In addition, the ABA has studied the issues of over-reliance on incarceration, as well as the high rates of recidivism that result from legal and practical barriers to prisoner reentry, and from high rates of parole revocations. In 2003, responding to the call by Justice Anthony M. Kennedy to the ABA to "help start a new public discussion" on "the inadequacies – and the injustices – in our prison and correctional systems," the ABA established the Justice Kennedy Commission ("Kennedy Commission").[6] Anthony M. Kennedy, *Speech at the A.B.A. Annual Meeting* (Aug. 9, 2003).

In 2004, the ABA House of Delegates adopted the Kennedy Commission's report, which concluded that, while there was no universally accepted view of the goal or purpose of punishment, there was a growing consensus that (a) incarceration, while appropriate for many crimes, should not be the only option; (b) when incarceration is imposed, society and offenders benefit when offenders are prepared to reenter society; (c) there is a place for harsh punishment, but also for rehabilitation; and (d) community-based treatment alternatives may be both cost-effective and conducive to safer communities. ABA JUSTICE KENNEDY COMMISSION, REPORTS AND RECOMMENDATIONS TO THE HOUSE OF DELEGATES 5 (2004) (hereinafter "Kennedy Comm'n Rep.").[7]

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[5] ABA CRIMINAL JUSTICE STANDARDS ON THE TREATMENT OF PRISONERS (2010), *available at* http://abanet.org/crimjust/standards/treatmentprisoners.html.

[6] Justice Kennedy did not participate in the work of the Commission or endorse any of its positions.

The ABA Commission on Effective Criminal Sanctions continued this work, conducting hearings across the country.[8] Its report, *Second Chances in the Criminal Justice System, Alternatives to Incarceration and Reentry Strategies,* is a compendium of the two commissions' work. Its recommendations, approved as ABA policy in 2007, were based on consensus views on what can be done to reduce reliance on incarceration and to reduce recidivism.[9] Its recommendations on community-based alternatives to incarceration and improvements to parole and probation supervision have been endorsed by the National District Attorneys Association, the National

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[7] *Available at* http://www.abanet.org/crimjust/kennedy/JusticeKennedyCommissionReportsFinal.pdf.

[8] The minutes of the Commission's public hearings are available at http://www.abanet.org/cecs/secondchances.pdf.

[9] The 2007 recommendations are available at http://www.abanet.org/cecs/secondchances.pdf.

Association of Criminal Defense Lawyers and the National Legal Aid and Defender Association.

These and other ABA commissions and task forces have heard and considered input from prosecutors, defenders, judges and academics, as well as officials and members of criminal justice organizations and correctional systems, and individuals with criminal records. Accordingly, the ABA respectfully suggests that its views may assist the Court as it considers whether the lower court's order should be affirmed.

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SUMMARY OF ARGUMENT

When a state holds a person in custody, it has a duty to provide that person with constitutionally adequate medical and mental health care. Prison overcrowding has been shown to have a number of deleterious effects on the medical and mental health of those who are held in prisons and jails, as well as those who work in these institutions. There are, however, many cost-effective prison population-reduction measures that may be safely and immediately implemented without need for legislative change, including (1) early release on exceptional and humanitarian grounds; (2) increased use of alternatives to incarceration for offenders, including those with substance abuse and/or mental illness problems, who are deemed to pose no substantial risk to public safety; (3) more effective parole and probation supervision policies that rely on graduated sanctions rather than automatic returns to prison; and (4) rehabilitative and reentry services aimed at reducing recidivism. Because the lower court appropriately left to California and its prison administrators the discretion to determine which methods to use to reduce its prison population without compromising public safety, the lower court's order should be affirmed.

◆

ARGUMENT

I. Overcrowding Has Been Shown to Have a Number of Deleterious Effects on the Medical and Mental Health of Prisoners.

The Eighth Amendment requires that a government provide medical care for those whom it has incarcerated. "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." *Estelle v. Gamble,* 429 U.S. 97, 103 (1976); *see also DeShaney v. Winnebago County Dep't. of Soc. Servs.*, 489 U.S. 189, 200 (1989) ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic needs – *e.g.*, food, clothing, shelter, medical care and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.").[10]

Prison overcrowding has long been shown to have a number of deleterious effects on the medical and mental health of prisoners and, once prisoners have been released, they "carry the effects or consequences of that harm back" to the communities to which they return. Craig Haney, *The Wages of Prison Overcrowding: Harmful Psychological Consequences and Dysfunctional Correctional Reactions*, 22 WASH. U.J.L. & POL'Y 265, 265 (2006). Earlier studies establish, for example, an association between crowding and elevated blood pressure and stress; and with elevated death rates in general and elevated suicide and violent death rates in particular. Terrence P. Thornberry & Jack E. Call, *Constitutional Challenges to Prison Overcrowding: The Scientific Evidence of Harmful Effect*, 35 HASTINGS L. J. 313, 344 and 351 (1983); *see also* Verne C. Cox, Paul B. Paulus, and Garvin McCain, *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach Regarding Crowding Phenomena*, 39 AM. PSYCH. 1156 (1984) (finding correlation between prison crowding and increased rates of death, suicide, disciplinary infraction, and psychiatric commitment).

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[10] *See also* ABA STANDARDS ON THE TREATMENT OF PRISONERS Standard 23-3.1(b) (2010) ("Government authorities . . . should take necessary steps to avoid crowding that exceeds a correctional facility's rated capacity or adversely affects the facility's delivery of core services at an adequate level, maintenance of its physical plant, or protection of prisoners from harm, including the spread of disease."), *available at* http://www.abanet.org/crimjust/standards/treatmentprisoners.html.

Further, "[u]nidentified and untreated mentally ill prisoners in mainline prison populations not only are more likely to deteriorate themselves, but also to have a significant adverse effect on the prisoners with whom they must live and interact." Haney, *supra*, at 273. One reason why these prisoners have become a larger proportion of the prison population was discussed in an ABA report in 2004, which cited one Chicago-based study that showed that people with mental illness were almost twice as likely to be arrested as people without mental illness for the same behavior. ABA, REPORT WITH RECOMMENDATION No. 116 4-5 (Policy adopted Feb. 2004).[11]

Overcrowding exacerbates other problems as well. It not only creates extra demand for medical and mental health services but it also causes a prison's facilities to deteriorate faster, further taxing its ability to provide for basic human needs. Wayne N. Welsh, *The Dynamics of Reform Litigation: A Comparative Analysis of Litigation in California Counties*, 26 LAW & SOC'Y REV. 591, 604-05 (1992). Overcrowding has also been shown to have a detrimental impact on the mental and physical well-being of prison staff. James Austin, *Using Early Release to Relieve Prison Crowding: A Dilemma in Public Policy*, 32 CRIME & DELINQUENCY 404, 411 (1986).

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[11] *Available at* http://www.abanet.org/leadership/2004/dj/116.pdf.

As this data-driven literature makes plain, overcrowded correctional facilities produce environments that have deleterious effects on the medical and mental health of prisoners, and can result in grave contraventions of the Eighth Amendment.

II. Cost-Effective Measures Exist to Reduce Prison Populations Consistent with Public Safety.

In studying the problems generated by expanding prison populations nationwide, the ABA has identified specific, cost-effective measures that jurisdictions can take to safely reduce overcrowding, without need for legislative change. The recommendations of the ABA's Commission on Effective Criminal Sanctions and the Kennedy Commission include the following, each of which is discussed below: (1) early release on exceptional and humanitarian grounds; (2) increased use of alternatives to incarceration for offenders, including those with substance abuse and/or mental illness problems, who are deemed to pose no substantial risk to public safety; (3) more effective parole and probation supervision policies that rely on graduated sanctions rather than automatic returns to prison; and (4) rehabilitative and reentry services aimed at reducing recidivism. Kennedy Comm'n Rep., *supra* 4, note 8, at 22-24, 29-34, 64-71, 76-86; ABA COMMISSION ON EFFECTIVE CRIMINAL SANCTIONS, SECOND CHANCES IN THE CRIMINAL JUSTICE SYSTEM: ALTERNATIVES TO

INCARCERATION AND REENTRY STRATEGIES 12-27 (2006) (hereinafter, "Alternatives to Incarceration").[12]

The implementation of such measures has resulted in prison population reductions in a number of states, with no adverse effect on public safety. *See, e.g.*, JUDITH GREENE & MARC MAUER, THE SENTENCING PROJECT, DOWNSCALING PRISONS: LESSONS FROM FOUR STATES (2010) (hereinafter "Greene & Mauer") (reviewing methods by which substantial prison population reductions have been safely achieved in New Jersey, Michigan, New York and Kansas).[13] In fact, data indicate that, in 2009, the prison population was reduced in 26 states, and for the first time in 38 years, the overall number of people in state prisons nation-wide declined by .3%. PEW CENTER ON THE STATES, PRISON COUNT 2010: STATE POPULATION DECLINES FOR THE FIRST TIME IN 38 YEARS (2010) (hereinafter "Prison Count 2010").[14] In 2009, Michigan, for example, safely reduced its prison population by 6.7% by reducing the number of prisoners who serve more than 100% of their minimum sentence, decreasing parole revocation rates and enhancing reentry planning and supervision through the Michigan Prisoner Reentry Initiative. *Id.* at 3.

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[12] *Available at* http://www.abanet.org/cecs/secondchances.pdf

[13] *Available at* http://www.sentencingproject.org/doc/publications/publications/inc_DownscalingPrisons2010.pdf.

[14] *Available at* http://www.pewcenteronthestates.org/report_detail.aspx?id=57653.

The following methods to reduce crowding could be safely and promptly implemented by California with changes in policy or an expansion of already existing state authority:

Early Release on Exceptional and Humanitarian Grounds. Sentence reduction should be broadly available in exceptional circumstances arising after sentencing, including old age, disability, changes in the law, exigent family circumstances, heroic acts, or extraordinary suffering. The ABA recommends that states "establish standards and provide an accessible process by which prisoners may request [such] a reduction of sentence" and "ensure that there are procedures in place to assist prisoners who are unable to advocate for themselves." Kennedy Comm'n Rep., *supra* 4, note 8, at 64. In accordance with these recommendations, many states employ administrative or judicial sentence reduction mechanisms, while others rely upon executive clemency to secure a prisoner's early release. *See* VERA INSTITUTE OF JUSTICE, IT'S ABOUT TIME: AGING PRISONERS, INCREASING COSTS AND GERIATRIC RELEASE (2010);[15] *see also* Cecelia M. Klingele, *Changing the Sentence Without Hiding the Truth: Judicial Sentence Modification as a Promising Method of Early Release*, 52 WM. & MARY L. REV. (forthcoming Nov. 2010), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1576131.

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[15] *Available at* http://www.vera.org/content/its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.

In Michigan, for example, sentence commutations have played a key role in prison population reduction in the last two years. Bethany Biron, *Granholm Approves 100 Commutation Requests in the Past Two Years*, The Mich. Daily, Oct. 1, 2010.[16] In Wisconsin, responding to fiscal constraints, the legislature expanded the category of those eligible for sentence reduction beyond those that are elderly or ill, and provided new administrative procedures to supplement the courts' existing authority. Gregory J. O'Meara, *Compassion and the Public Interest, Wisconsin's New Compassionate Release Legislation*, 23 FED. SENT. RPTR. 33, 34 (2010).

In California, Governor Schwarzenegger recently signed into law SB 1399, authorizing the California Board of Parole Hearings to grant immediate parole based on certain medical indications.[17] The new law provides for medical parole for incapacitated prisoners who are permanently unable to perform activities of basic daily living and require 24-hour care, provided that the Board determines the prisoner not to reasonably pose a threat to public safety. *Id.* California could consider extending this parole authority to other extraordinary circumstances.[18]

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[16] *Available at* http://www.michigandaily.com/content/granholm-approves-100-commutation-requests-past-two-years.

[17] *Available at* http://info.sen.ca.gov/pub/09-10/bill/sen/sb_1351-1400/sb_1399_bill_20100928_chaptered.pdf.

[18] The most recent draft of the American Law Institute's MODEL PENAL CODE: SENTENCING recommends a variation of this

(Continued on following page)

Increased Use of Sentencing Alternatives for Offenders Who Are Deemed to Pose No Substantial Risk to Public Safety. Increased use of sentencing alternatives can be safely implemented to reduce the number of offenders added to existing prison populations. The ABA recommends that states develop, with the assistance of prosecutors and others, community-based diversion or deferred adjudication and supervision programs for offenders who are deemed to pose no substantial threat to the community. These include community-based treatment programs for offenders whose crimes are related to substance abuse and/or mental illness. The ABA suggests that these types of programs will be most effective when offenders are provided, in appropriate cases, with an opportunity to complete a program without a criminal record, since the collateral consequences of conviction can make it difficult for offenders to get a job or housing or, generally, to put their lives back on track. Alternatives to Incarceration, *supra* 10, note 13, at 12. The ABA also recommends that jurisdictions not exclude offenders with drug or mental health issues because they have a prior conviction or a history of

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humanitarian parole by providing for judicial sentence reduction for prisoners who are aged and infirm, or whose situation otherwise presents other compelling circumstances *See* § 305.7, Council Draft #3 at 85 (October 1, 2010) ("Modification of Prison Sentences in Circumstances of Advanced Age, Physical or Mental Infirmity, Exigent Family Circumstances, or Other Compelling Reasons"), *available at* http://extranet.ali.org/docs/Model%20Penal_Code_CD3_Booked%20-%20entire.pdf.

minor violence, since relapse is often a predictable part of recovery. *Id.* New York and New Jersey recently implemented such diversionary programs to reduce prison population. New York's *Drug Treatment Alternative to Prison Program* diverts drug users charged with non-violent crimes to treatment for addiction, while in New Jersey, plea negotiation guidelines were revised to allow "open pleas" in lower-level drug-free zone cases, giving judges greater discretion to consider drug treatment as an alternative to incarceration. Greene & Mauer, *supra* 10, note 14, at 3; *see also* Alternatives to Incarceration, *supra* 10, note 13, at 10-15 (discussing programs). California already permits diversionary programs. *See, e.g.,* Cal. Penal Code § 17(b)(4).

Improvements in Parole and Probation Supervision. Improvements to parole and probation supervision can contribute substantially to reducing prison populations and recidivism: parole and probation violators account for more than one-third of all prison admissions, and more than two-thirds of those admissions were for a violation of the conditions of release, rather than commission of a new offense. Alternatives to Incarceration, *supra* 10, note 13, at 20. Revocations often follow minor violations of the terms of supervised release and do not reflect conduct posing a threat to the community. *Id.* The ABA urges, instead, the use of graduated sanctions, which return an offender to prison only on commission of a new crime or when the offender poses a danger to the community. *Id.*

Some states have safely conserved supervision resources by avoiding the over-regulation of low-risk offenders and targeting higher-risk offenders. *Maximum Impact: Targeting Supervision on Higher Risk People, Places and Times*, PUBLIC SAFETY POLICY BRIEF (Pew Ctr. on the States, Washington, D.C.), July, 2009.[19] Kansas, Georgia, and New Jersey have reduced revocations for rule violations without an increase in new criminal behavior by parolees. *When Offenders Break the Rules – Smart Responses to Parole and Probation Violations*, PUBLIC SAFETY POLICY BRIEF (Pew Ctr. on the States, Washington, D.C.), Nov. 2009, at 5, n.21;[20] *see also* Alternatives to Incarceration, *supra* 10, note 13, at 20-24 (discussing programs).

In addition, some states have developed mechanisms for increasing the number of prisoners who can be safely paroled. Michigan and New Jersey use risk assessment tools to distinguish such inmates from those who need to remain behind bars. *See, e.g.*, Greene & Mauer, *supra* 10, note 14, at 4. Texas has similarly increased its parole grant rate and shortened probation terms. Prison Count 2010, *supra* 11, note 15, at 3-4.[21]

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[19] This brief is available on the Pew Center's website, at http://www.pewcenteronthestates.org/uploadedFiles/Maximum_Impact_web.pdf.

[20] This brief is available on the Pew Center's website, http://www.pewcenteronthestates.org/report_detail.aspx?id=32104.

Rehabilitative and Reentry Services To Reduce Recidivism. The ABA recognizes that additional resources are often not available to provide expanded services during the early weeks of re-entry. However, the ABA recommends that existing resources should be reallocated to those offenders with the greatest need. Research has shown that some offenders do not need intensive supervision and may be better off without it. Alternatives to Incarceration, *supra* 10, note 13, at 21-22. Focusing resources, instead, on high-risk offenders who pose the greatest risk of returning to criminal behavior holds the opportunity to reduce overall recidivism and to promote public safety. *Id.*

Many states have adopted measures to help prepare offenders to live law-abiding lives upon release. *See generally Reentry Programs Database*, Reentry Policy Council, http://www.reentrypolicy.org/reentry-program-examples/reentry-programs-start (last visited Oct. 29, 2010). Michigan, for example, developed the Michigan Prisoner Reentry Initiative, which provides services in areas like housing, employment, and substance abuse to avoid recidivism. *See* MICHIGAN PRISONER REENTRY INITIATIVE, http://www.michpri.com (last visited Oct. 29, 2010). Programs such as these have increased the success rates of offenders transitioning from prison into the community and have reduced the number of recidivists. As the Attorney General recently noted, "sound science and evidence-supported strategies" guide model reentry programs across the nation; "public safety can improve, and taxpayers can see significant savings, when people who commit crimes are served by high-quality community supervision and programs where services and sanctions work in unison." Eric H. Holder, Speech at the European Offenders Employment Forum (Oct. 8, 2010), *available at* http://www.justice.gov/iso/opa/ag/speeches/2010/ag-speech-101008.html.

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[21] The Pew Center also reported that advances in supervision technology, such as Global Positioning System monitors, rapid-result drug tests and ATM-like reporting kiosks give authorities greater confidence that they can protect public safety and hold offenders accountable with sanctions other than incarceration. *Id.* at 6.

There are many other cost-effective measures that can be implemented without unduly jeopardizing public safety or the operation of a jurisdiction's criminal justice system. In the present case, the lower court appropriately left to California and its prison administrators the discretion to determine which methods to use, while mandating that those methods be consistent with public safety and that California provide constitutionally required conditions for prison inmates. The ABA therefore submits that California can and should reduce its prison population consistent with that order.

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CONCLUSION

For the foregoing reasons, *amicus curiae* American Bar Association requests that the judgment of the three-judge court below be affirmed.

Respectfully submitted,

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No. 09-1233

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OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, ET AL.,
Appellants,

—v.—

MARCIANO PLATA and RALPH COLEMAN, ET AL.,
Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURTS FOR THE
EASTERN DISTRICT OF CALIFORNIA AND THE
NORTHERN DISTRICT OF CALIFORNIA

BRIEF *AMICI CURIAE* OF THE AMERICAN CIVIL LIBERTIES UNION, HUMAN RIGHTS WATCH, THE LEADERSHIP CONFERENCE ON CIVIL AND HUMAN RIGHTS, AND PENAL REFORM INTERNATIONAL/THE AMERICAS

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INTEREST OF *AMICI*[1]

The interests of *amici* are set forth in an appendix to this brief.

INTRODUCTION

This case involves ongoing, undisputed, and lethal constitutional violations in the California state prison system. As the lower court found, and the State does not dispute, "the medical and mental health care available to inmates in the California prison system is woefully and constitutionally inadequate, and has been for more than a decade." JS1-App. 8a. Despite findings of Eighth Amendment violations in 2002 (medical care) and 1995 (mental health care), and the entry of dozens of remedial orders by the *Coleman* and *Plata* district courts, State officials have been unable or unwilling to bring their prison health care system into compliance with minimal constitutional standards.

The lower court also found, and the State again does not dispute, that "California's inmates face a second everyday threat to their health and safety: the unprecedented overcrowding of California's prisons." *Id.* at 9a. The State's prisons have for years operated at nearly double their intended capacity, with some institutions approaching 300% of capacity. Governor Schwarzenegger, in declaring a prison emergency that continues to this day, observed that this creates "conditions of extreme peril" that threaten "the health and safety of the men and women who work inside [severely overcrowded] prisons and the inmates housed in them[.]" *Id.* The State's independent oversight agency has concluded that "California's correctional system is in a tailspin." *Id.* at 8a.

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[1] The parties have lodged blanket consents to the filing of *amicus* briefs with the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amici* states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief.

Faced with severe and ongoing constitutional violations, the *Coleman* and *Plata* district courts requested the convening of a three-judge court to consider whether a prisoner release order should be entered under the requirements set forth in the Prison Litigation Reform Act (PLRA). *See* 18 U.S.C. § 3626(a)(3)(D). The three-judge court conducted a lengthy trial and ultimately found by clear and convincing evidence that (1) crowding is the primary cause of the ongoing violation of plaintiffs' Eighth Amendment rights, and (2) no other relief will remedy those violations. *See* 18 U.S.C. § 3626(a)(3)(E). Accordingly, the lower court entered a prisoner release order, directing the State to reduce its prison population to 137.5% of the system's design capacity within two years.[2]

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[2] Under the PLRA, a "prisoner release order" includes "any order ... that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison[.]" 18 U.S.C. § 3626(g)(4). Thus, while the lower court's order does not actually require the release of prisoners from the California

The State now appeals, contending that the lower court's order is barred by the PLRA. The State's arguments are, individually and collectively, without merit. Moreover, if accepted, they would render prisoner release orders unavailable, even when necessary to cure ongoing constitutional violations.

This case is unique in its intersection between severe and longstanding Eighth Amendment violations, and extreme and persistent crowding. Simply put, if a prisoner release order is not available on this record, it is an illusory remedy. The State's proffered interpretation of the PLRA cannot be squared with the statutory language or the legislative history; it would also raise serious constitutional questions and contravene the treaty and other international law obligations of the United States. For these reasons, this Court should decline the State's invitation; the order below should be affirmed.

SUMMARY OF ARGUMENT

Both the plain language and the legislative history of the PLRA make clear that Congress intended to preserve the availability of prisoner release orders when necessary to redress constitutional violations. The PLRA's prisoner release provisions were motivated primarily by cases in which population caps had been imposed in the absence of any finding of a constitutional

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prison system, it nevertheless qualifies as a "prisoner release order" under the statute.

violation. That concern has no application in this case, in which constitutional violations were found in 2002 and 1995 and persist today despite dozens of remedial orders.

The State's challenge to the three-judge court's jurisdiction based on allegedly erroneous findings by the single-judge district courts is not properly before this Court on direct appeal. The general rule is that this Court's direct appellate jurisdiction extends only to orders actually entered by three-judge courts, and no exception to that rule applies here. Any error underlying the single-judge courts' requests to convene a three-judge court did not affect that court's ruling on the merits, and it is that ruling that is properly before this Court.

Contrary to the State's contention, the three judge court was not required to reconsider the constitutional violations found by the single-judge *Plata* and *Coleman* courts. Congress required a finding of "current and ongoing" violations in a different section of the PLRA, but not in the sections governing the entry of prospective relief in general or prisoner release orders in particular. Nor was the three-judge court barred by the PLRA from establishing a reasonable cut-off date for evidence it would admit at trial. Moreover, any error in this respect was harmless, since the State does not identify a single piece of evidence it contends was erroneously excluded by the three judge court.

Finally, the State advances a highly restrictive construction of the PLRA which, if accepted, would render prisoner release orders unavailable as a practical matter. A construction that would make such orders unavailable even when necessary to cure ongoing constitutional violations would raise serious constitutional questions, and therefore should be avoided if possible. Moreover, under international law, including treaties ratified by the United States, failure to provide prisoners with adequate medical and mental health care can constitute torture or cruel, inhuman or degrading treatment. Because states are required to make available effective legal remedies to victims of such treatment, a construction of the PLRA that makes prisoner release orders *de facto* unavailable would contravene these international law obligations. This Court should accordingly adopt a construction of the PLRA that does not raise these grave constitutional and international law concerns, and should affirm the order below.

ARGUMENT

I. CONGRESS INTENDED PRISONER RELEASE ORDERS TO REMAIN AVAILABLE UNDER THE PLRA.

It is beyond dispute that Congress intended prisoner release orders to remain available under the PLRA. This is plain from the language of the statute, which explicitly provides for prisoner release orders when necessary to redress ongoing constitutional violations. *See* 18 U.S.C. § 3626(a)(3). "We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v.*

Germain, 503 U.S. 249, 253-54 (1992). More to the point, when Congress explicitly authorizes a remedy, that remedy must not be construed so restrictively as to be illusory. *See Graham v. Bhd. of Locomotive Firemen and Enginemen*, 338 U.S. 232, 240 (1949) (holding that injunctive relief was available to enforce the right to nondiscriminatory treatment enacted in the Railway Labor Act; "there is nothing to suggest that, in enacting the subsequent Railway Labor Act provisions insuring petitioners' right to nondiscriminatory representation by their bargaining agent, Congress intended to hold out to them an illusory right for which it was denying them a remedy").

Moreover, the legislative history of the PLRA makes clear that Congress did not intend prisoner release orders to be unavailable in cases of longstanding and undisputed constitutional violations. "While prison caps must be the remedy of last resort, a court still retains the power to order this remedy despite its intrusive nature and harmful consequences to the public if, but only if, it is truly necessary to prevent an actual violation of a prisoner's federal rights." H.R. Rep. No. 104-21, at 25 (1995). The House Report explained that statutory restrictions on population caps were needed to "end the current practice of imposing prison caps when inmates in local prisons have complained about the prison conditions *but the presiding judge has made absolutely no finding of unconstitutionality or even held any trial on the allegations*." H.R. Rep. No. 104-21, at 25 (emphasis added). These concerns simply have no application in these cases, in which Eighth Amendment violations were established in 1995 and 2002 and persist today despite dozens of remedial orders.

The legislative history shows that the prisoner release provisions of the PLRA were motivated in large part by Congressional reaction to the consent decree in *Harris v. Pernsley,* 654 F. Supp. 1042 (E.D. Pa. 1987), which imposed population caps in the Philadelphia prison system. *See* H.R. Rep. No. 104-21, at 9; 141 Cong. Rec. S14316 (Sept. 26, 1995) (Statement of Sen. Abraham); 141 Cong. Rec. S14414 (Sept. 27, 1995) (Statement of Sen. Dole). But the *Harris* decree bears little resemblance to the lower court order in this case.

First and most significantly, the *Harris* decree was entered by consent, and in the absence of any judicial finding of a constitutional violation. 654 F. Supp. at 1045. The *Harris* decree was also far more intrusive than the order at issue here: it banned the housing of more than two prisoners in a cell, as well as housing in "any gymnasium, corridor or bench area, or any area not set up for permanent housing;" it imposed numerical population caps, both for the system as a whole and for each individual facility; and it required both the release of current prisoners and the nonadmission of new prisoners under certain circumstances. *Id.* at 1046-47. By contrast, the lower court's order here follows repeated findings of constitutional violations; sets a systemwide population limit, expressed as a percentage of capacity, which the State is free to meet through out-of-state transfers, new prison construction, or in any other way it chooses; and does not require the release or nonadmission of any prisoner.

The PLRA's prisoner release provisions were intended to put an end to *Harris*-like consent decrees, and they have effectively done so. There is no indication in the statutory text or legislative history that they were intended to bar the entry of the far less intrusive order at issue here, when necessary to redress ongoing and undisputed Eighth Amendment violations.

II. THE STATE'S CHALLENGE TO THE THREE-JUDGE COURT'S JURISDICTION BASED ON ALLEGEDLY ERRONEOUS FINDINGS BY THE SINGLE DISTRICT COURT JUDGES IS NOT PROPERLY BEFORE THIS COURT ON DIRECT APPEAL.

The State argues that the orders to convene the three-judge court in this case were premature, and that this Court should therefore vacate those orders and remand the case to the single-judge courts. This argument misconstrues the scope of this Court's direct review jurisdiction.

The general rule in three-judge court cases is that this Court's direct appellate jurisdiction extends only to "orders actually entered by three-judge courts." *Gonzalez v. Automatic Employees Credit Union*, 419 U.S. 90, 96 n.14 (1974). The one narrow exception is that this Court may review an order convening a three-judge court to determine whether the three-judge court has jurisdiction over the case,[3] but that jurisdictional review has been carefully confined to ensure that the exception does not swallow the rule. There are three lines of cases that address this exception.

In one line of cases, based on an earlier version of the three-judge court statute, this Court's review of the convening order focused on whether the challenged policy "ha[d] statewide application or effectuate[d] a statewide policy." *Bd. of Regents of the Univ. of Texas Sys. v. New Left Educ. Project*, 404 U.S. 541, 542 (1972). *See also, e.g.*, *Moody v. Flowers*, 387 U.S. 97, 104 (1967); *Rorick v. Bd. of Comm'rs*, 307 U.S. 208, 213 (1939); *Ex parte Pub. Nat'l Bank*, 278 U.S. 101, 104 (1928).[4] In conducting that review, however, the Court limited its inquiry to the face of the complaint and did not delve into factual disputes. For example, in *Moody v. Flowers*, the Court stated that its proper role was to "not accept the invitation to get into the niceties of the relationship between the provisions of the [county] charter and the New York County Law, but take the complaint as we find it for purposes of the jurisdictional question." 387 U.S. at 104. Similarly, in *Flast v. Cohen*, the Court relied solely on the allegations of the complaint to hold that the case would have statewide impact. 392 U.S. 83, 89-90 (1968).

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[3] In *Gully v. Interstate Natural Gas Co*, 292 U.S. 16, 18 (1934), the Court explained that it "necessarily has jurisdiction to determine whether the court below has acted within the authority conferred by [statute]."

[4] Under prior law, a three-judge court was required to enjoin the enforcement of a state statute on constitutional grounds. 28 U.S.C. § 2281, *repealed* by Pub.L. 94-381, 90 Stat. 1119 (1976). That is no longer the case.

In a second line of cases, this Court's review of the convening order has focused on whether the claim is so "insubstantial" that it cannot be heard by a three-judge court. *Bailey v. Patterson*, 369 U.S. 31, 33 (1962); *see also Ex Parte Poresky*, 290 U.S. 30, 32 (1933). In this context, "insubstantial" means that either the claim or all defenses to it are "legally speaking nonexistent" so that the issue presented "is essentially fictitious." *Bailey*, 369 U.S. at 33. Like statewide impact, the insubstantiality inquiry "must be determined by the allegations of the bill of complaint." *Poresky*, 290 U.S. at 32.

Finally, in a third line of cases, this Court has determined whether the cause of action falls within the language of a statute calling for a three-judge court. *See, e.g., Allen v. State Bd. of Elections*, 393 U.S. 544, 560-63 (1969) (holding that three-judge court was properly convened because Congress intended suits under § 5 of the Voting Rights Act to be heard by three-judge courts); *Swift & Co. v. Wickham*, 382 U.S. 111, 128-29 (1965) (holding that three-judge court was improperly convened because 28 U.S.C. § 2281 does not call for a three-judge court to hear Supremacy Clause cases that involve only federal-state statutory conflicts).

In each of these three lines of cases, this Court's review of the convening order has been limited to examining the allegations of the complaint to identify whether the three-judge court has jurisdiction to hear the case. Here, the three-judge court's jurisdiction derives from 18 U.S.C. § 3626(a)(3)(B), which states in relevant part: "In any civil action in Federal court with respect to prison conditions, a prisoner release order shall be entered only by a three-judge court . . ." Neither party has challenged the conclusion that the plaintiffs sought a prisoner release order, and therefore satisfied the jurisdictional prerequisite for a three-judge court.

The State's argument instead rests on a red herring. Specifically, the State contends that the district judges in *Coleman* and *Plata* erred in finding that the State had had a "reasonable amount of time to comply with the previous court orders," 18 U.S.C. § 3626(a)(3)(A)(ii), and therefore erred in requesting a three-judge court. That alleged error, the State contends, is reviewable by this Court on direct appeal. For the reasons set forth below, the State is wrong.

Even assuming *arguendo* that the single-judge courts erred, that error did not divest the three-judge court of jurisdiction because it neither changed the relief sought nor affected the merits of the three-judge court's later prisoner release order. *Hicks v. Miranda*, 422 U.S. 332 (1975), is instructive. In that case, the convening order failed to appoint the original district judge as a member of the three-judge panel, which violated 28 U.S.C. § 2284(b)(1). This Court held that the error was non-jurisdictional. 422 U.S. at 338 n.5. Like the composition of the three-judge panel, the question of whether the "reasonable time" requirement was met at the time the three-judge panel was first convened has no impact on the merits of the prisoner release order that is now before the Court. That is because the three-judge court was required to find, and did find, that no relief other than a prisoner release order would remedy the violation of the prisoners' constitutional rights. 18 U.S.C. § 3626(a)(3)(E)(ii). This independent finding by the three-judge court was the "merits" ruling on this issue, not any previous "reasonable time" finding by the single district court judges.

Thus, review of the single-judge courts' "reasonable time" determination should be governed by the general rule that errors by the single-judge district court that do not go to the merits of the three-judge court's ruling are reviewed by the court of appeals, not this Court. *See, e.g., In re Slagle*, 504 U.S. 952 (1992) (White, J.) (opining that this Court lacks jurisdiction over a petition for mandamus to disqualify an individual member of a three-judge court); *Gonzalez*, 419 U.S. at 101 ("We hold, therefore, that . . . [for] a refusal to request the convention of a three-judge court ab initio, review of the denial is available only in the court of appeals"); *Hicks v. Pleasure House, Inc.*, 404 U.S. 1, 3 (1971) (holding that single district judge's issuance of a temporary restraining order after ordering the convening of a three-judge court is reviewable by the three-judge court or by the court of appeals, but not by the Supreme Court); *Mitchell v. Donovan*, 398 U.S. 427, 430-31 (1970) (holding that a three-judge court's order granting or denying only a declaratory judgment, without granting or denying injunctive relief, is not directly appealable to this Court). "While issues short of the merits . . . are often of more than trivial consequence, that alone does not argue for [this Court's] reviewing them on direct appeal." *Gonzalez*, 419 U.S. at 99.

Moreover, whether the single-judge court gave the State a "reasonable amount of time" to comply with its orders is a fact-intensive question that is uniquely ill-suited to direct Supreme Court review. To decide this issue, the *Plata* and *Coleman* courts engaged in a detailed analysis that traced the progress of the cases and the State's remedial efforts over a twelve-year period, evaluated the role played by the Receiver, identified the relevant findings in the Receiver's reports, and considered the possible impact of recent legislative and executive action. JS1-App. 278a-285a; 289a-304a. This detailed factual inquiry relies heavily on the district courts' familiarity with the cases and the parties, and is wholly unlike the questions of law that define the three-judge court's jurisdiction. *Compare, e.g.*, *Moody*, 387 U.S. at 104 (relying solely on the allegations of the complaint to determine whether the three-judge court was properly convened); *Flast*, 392 U.S. at 89-90 (same); *Poresky*, 290 U.S. at 32 (same).

Vacating the convening order would also be inconsistent with the purposes of the three-judge court statute because it would pointlessly waste judicial resources. At this late stage, even if the single-judge courts convened the three-judge court more than a year too early, that error is harmless.[5] Thus, vacating the convening order would likely result in an order to reconvene the three-judge court, another three-judge trial, and another direct appeal to this Court by the party that loses at the second trial. This would consume considerable judicial resources for no good reason. *See Gonzalez*, 419 U.S. at 98 (noting that Congress intended the three-judge-court statute to both "ensur[e] this Court's swift review of three-judge-court orders that grant injunctions" and "minimiz[e] the mandatory docket of this Court in the interests of sound judicial administration"); *Phillips v. United States*, 312 U.S. 246, 250 (1941) (noting that in enacting the three-judge-court statute, Congress was "mindful that the requirement of three judges . . . entails a serious drain upon the federal judicial system").

Finally, regardless of which court is the proper venue for reviewing the single-judge courts' adherence to 18 U.S.C. § 3626(a)(3)(D)'s procedural requirements, that review should give great deference to the single-judge courts' determination of reasonableness. *See Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 403-04 (1990) (adopting an abuse-of-discretion standard for reviewing district court's reasonableness determination in Rule 11 proceedings). Whether the State was given "a reasonable amount of time" to comply with numerous court orders issued across more than a decade of litigation is exactly the kind of "multifarious and novel question, little susceptible . . . of useful generalization" that lends itself to an abuse-of-discretion standard of review. *Pierce v. Underwood*, 487 U.S. 552, 562 (1988) (adopting an abuse-of-discretion standard for reviewing district court's determination that government's litigation position was not "substantially justified" for purposes of a fee award under Equal Access to Justice Act). The district courts' reasonableness determination was based on a careful and thorough review of the record; the State has not pointed to anything that would make it clearly erroneous. Accordingly, the convening orders should be left undisturbed, even if there is jurisdiction to review them.

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[5] The State cannot seriously argue, nor has it argued, that it has not yet had a reasonable opportunity to remedy its constitutional violations.

III. APPELLANTS MISSTATE AND MISAPPREHEND THE ROLE OF THE THREE-JUDGE COURT UNDER THE PLRA.

A. The PLRA Does Not Require Three-Judge Courts To Reconsider The Constitutional Violations Previously Found By A Single Judge.

Under the PLRA, the responsibility for deciding whether prison conditions violate the Eighth Amendment is assigned to a single district judge. Here, the *Plata* and *Coleman* courts made two findings of unconstitutional conditions: one involving mental health care and one involving medical care. Consistent with the PLRA, the district judges then issued a series of remedial orders that, for years, proved inadequate to cure the constitutional violations. If the State believed at any point that its prisons had achieved constitutional compliance, it was entitled under the PLRA to assert that position in a termination motion before the district court. It never did so.

Faced with this situation, the district judges who had supervised the litigation from the outset and were therefore intimately familiar with conditions in the California prison system as well as the State's history of noncompliance, requested a three-judge court to consider a prisoner release order as a last resort. In so doing, they followed the exact procedure set forth by Congress in the PLRA. Contrary to the State's assertion, the PLRA does not require the three-judge court to find that the previously adjudicated constitutional violations are "current and ongoing" as a predicate to issuing a release order. Rather, the PLRA specifically requires two different findings by the three-judge court: first, that "crowding is the primary cause of the violation of a Federal right," 18 U.S.C. § 3626(a)(3)(E)(i); and second, that "no other relief will remedy the violation of the Federal right," 18 U.S.C. § 3626(a)(3)(E)(ii).

The three-judge court in this case made both the required findings. Moreover, in making these findings, the three-judge court considered extensive evidence introduced by both sides regarding current conditions in the California prisons. The State does not cite *any* evidence regarding current conditions that the three-judge court refused to consider.[6]

The State's contention that the three-judge court was additionally required to reconsider the underlying constitutional violations found by the *Coleman* and *Plata* district judges would, if adopted, seriously disrupt the PLRA's careful division of judicial responsibilities. Not surprisingly, it finds no support in the language or structure of the PLRA.

1. Congress knows how to mandate a specific finding of "current and ongoing" violations when it wants to do so. Indeed, Congress did precisely that in a provision of the PLRA that does *not* apply to the ruling of the three-judge court. In a prison conditions case, a defendant may make a motion to terminate prospective relief in a single-judge district court two years after issuance of the relevant injunction or consent decree, and every year thereafter. 18 U.S.C. § 3626(b)(1)(A). The motion to terminate must be granted unless the district court "makes written findings based on the record that prospective relief remains necessary to correct a *current and ongoing* violation of the Federal right." 18 U.S.C. § 3626(b)(3) (emphasis added); *see also Miller v. French*, 530 U.S. 327, 333 (2000).

By contrast, provisions of the same statute that address the initial entry of prospective relief in general, and prisoner release orders in particular, do not mention "current and ongoing" violations. Specifically, § 3626(a)(1)(A), which defines the requirements for initial entry of prospective relief, does not mention "current and ongoing" violations.[7] Nor does § 3626(a)(3), which prescribes requirements first to convene a three-judge court and then for such a court to enter a prisoner release order. 18 U.S.C. § 3626(a)(3).

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[6] *Plata* Appellees' Br. at 36

"[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Gozlon-Peretz v. United States*, 498 U.S. 395, 404 (1991) (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)). Congress' selective inclusion of the phrase "current and ongoing violation[s]" demonstrates that the PLRA did not require the three-judge court to make a finding of such violations separate from and in addition to its remedial findings.

2. If the State sought a separate finding regarding current and ongoing violations, the PLRA provided, as the three-judge court noted,

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[7] *See Thomas v. Bryant*, 614 F.3d 1288, 1320 (11th Cir. 2010) ("[T]he 'current and ongoing' requirement is distinct from the standard governing the initial entry of injunctive relief." PLRA does not bar injunctive relief "to prevent a substantial risk of serious injury from ripening into actual harm"); *Austin v. Wilkinson*, 372 F.3d 346, 360 (6th Cir. 2004) ("[T]he 'current and ongoing' language comes from § 3626(b)(3), governing the *termination* of relief, not from § 3626(a), governing requirements for initial relief.") (emphasis in original), *rev'd in part on other grounds*, 545 U.S. 209 (2005)).

the "proper means" for doing so – a motion to terminate prospective relief brought in the single-judge district courts under § 3626(b). JS1-App. 77a. The single-judge courts not only would have ruled on such a motion but would have done so "promptly," with prospective relief automatically stayed 30 (or at most 90) days after the motion was filed, and mandamus available to the State "to remedy any failure to issue a prompt ruling." 18 U.S.C. § 3626(e)(1), (2), and (3); *see also Miller*, 530 U.S. at 333.

The three-judge court invited the State to contest current violations in the single-judge district courts.[8] In *Coleman*, however, the State failed to bring a motion to terminate. And in *Plata*, the State brought such a motion but challenged only the legality of the receivership as a legal matter without disputing the existence of "present constitutional violations." *Plata v. Schwarzenegger*, 603 F.3d 1088, 1097 (9th Cir. 2010).

3. Having failed to contest current and ongoing violations through the proper mechanism, the State is left to argue that a motion to terminate would have required "a showing that *all* constitutional violations had been remedied," preventing the State from conceding the existence, but disputing the extent, of current violations. State Br. at 27. Not true. The single-judge courts could have granted a motion to terminate in part based on the scope of

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[8] *See Plata* Appellees' Mot. To Dismiss or Affirm at 29-30 n.3 (citing Pretrial Conf. Tr. 28-29 (Nov. 10, 2008)).

current violations – if only the State had brought the motion.[9]

B. The District Court Established A Reasonable Cutoff Date for New Evidence.

Facing a massive trial that would span fourteen court days, involve hundreds of exhibits, and include live testimony from almost 50 witnesses and written testimony from many more, JS1-App. 70a, the court set a cutoff date for new evidence roughly two and a half months before trial.[10] This, says the State, was reversible error. State Br. at 27-28. In truth, the court prevented unfair surprise and acted well within the bounds of its discretion in establishing the cutoff date.

1. Without a cutoff date for new evidence in prison conditions cases, counsel for prisoners would have no way to refute last-minute representations about changed circumstances. Plaintiffs' counsel could not review documents

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[9] *Pierce v. Cnty. of Orange*, 526 F.3d 1190, 1206 (9th Cir. 2008) (stating that the extent to which prospective relief may be terminated depends on "the extent of the current and ongoing constitutional violations").

[10] The Court set an August 30, 2008 cutoff date, *Plata* D.E. 1294, at 3 ¶ 2.e, and trial commenced on November 18, 2008, JS-1 App. 70a. The state even presented evidence of conditions after August 30, 2008 at trial. Def. Ex. 1100; Tr. 1895:15-18; Tr. 800:8-10; Tr. 852:1-4; Tr. 860:2-10; Tr. 1914:10-12; Tr. 1894.11-14.

about new policies that prison officials claim to have implemented on the eve of trial, or visit prisons to observe supposedly new conditions. In large-scale trials about prison conditions, cutoff dates provide a commonplace mechanism to address the parties' asymmetrical access to current information about prisons owned and managed by the defendants. *See, e.g., Graves v. Arpaio*, 2008 WL 4699770, at *2, *3 (D. Ariz. 2008) (district court established an evidentiary cut-off date approximately two and a half months before commencement of hearing on defendants' motion to terminate relief under the PLRA).

In this case, the order that set the cutoff date prevented *both* plaintiffs and defendants from taking unfair advantage of new information. *Plata* D.E. 1294, at 3 ¶ 2.e. The order – at the State's request – barred plaintiffs' counsel from visiting prison facilities after the cutoff date. *Coleman* Appellees' Br. at 50. The order symmetrically prevented defendants from introducing evidence regarding conditions (other than legislative changes) that post-dated plaintiffs' last opportunity to visit the prisons. *Plata* D.E. 1294, at 3 ¶ 2.e. Defendants ultimately made a strategic choice not to challenge the order.

2. The establishment of a cutoff date shortly before trial fell within the proper discretion of the three-judge court and should not be disturbed on appeal. Appellate courts defer "to a district court's familiarity with the details of the case and its greater experience in evidentiary matters" and "afford broad discretion to a district

court's evidentiary rulings." *Sprint/United Mgmt. Co. v. Mendelsohn*, 552 U.S. 379, 384 (2008). This Court has emphasized a district court's discretion in prison cases to limit, or not to limit, evidence of changed conditions. *Farmer v. Brennan*, 511 U.S. 825, 846 (1994) (stating that, in establishing deliberate indifference in an action for injunctive relief, prisoners "may rely, *in the district court's discretion*, on developments that postdate the pleadings and pretrial motions, as the defendants may rely on such developments to establish that the inmate is not entitled to an injunction") (emphasis added).

The three-judge court properly exercised its discretion here. The larger a prison system and the more complex a trial, the earlier a cutoff date must fall to ensure that prison officials do not surprise plaintiffs with claims about dramatic changes that can be verified or refuted only by touring large and far-flung institutions, arranging similar visits for expert witnesses, and sifting through warehouses of documents. *Plata* and *Coleman* involved decades of litigation, an enormous record, and the largest state prison system in the United States. JS1-App. 56a, 70a. In these cases, measured as they must be in years and decades, the period between the cutoff date and trial was a tiny sliver of time.

IV. THE STATE'S ARGUMENTS, IF ACCEPTED, WOULD MAKE PRISONER RELEASE ORDERS UNAVAILABLE EVEN WHEN NECESSARY TO CURE ONGOING CONSTITUTIONAL VIOLATIONS.

"When conditions of confinement amount to cruel and unusual punishment, federal courts will discharge their duty to protect constitutional rights." *Rhodes v. Chapman*, 452 U.S. 337, 352 (1981) (quoting *Procunier v. Martinez*, 416 U.S. 396, 405-06 (1974)). Congress recognized that prisoner release orders will sometimes be necessary to cure ongoing constitutional violations, and therefore preserved their availability when enacting the PLRA.

The State advocates a construction of the PLRA in which judicial scrutiny of prisoner release orders is strict in theory but fatal in fact. The State's arguments, if accepted *in toto*, would render prisoner release orders unavailable as a practical matter. These arguments include:

1. Under the PLRA, a prisoner release order may not issue unless a court has previously entered an order for less intrusive relief and the defendant "has had a reasonable amount of time to comply with the previous orders." 18 U.S.C. § 3626(a)(3)(A). The State argues that, even if constitutional violations are longstanding and multiple remedial orders have failed to cure them, each additional order issued by the court starts the clock running anew, and bars the entry of a prisoner release order until some additional

indeterminate "reasonable amount of time" has elapsed. State Br. at 15-16.

2. The *Coleman* and *Plata* courts found ongoing constitutional violations, which the State did not contest. Nevertheless, the State argues that the three-judge court must allow constant relitigation of the constitutional violations, and may not establish a reasonable cut-off date for evidence it will hear at trial. State Br. at 26-30. In the State's view, the three-judge court is faced with an ever-moving target, in which evidence of constitutional violations can always be countered by last-minute representations by the State that, in light of the parties' asymmetrical access to the prisons, cannot effectively be challenged by plaintiffs.

3. The PLRA provides that a prisoner release order may not issue unless the three-judge court finds by clear and convincing evidence that "crowding is the primary cause" of the constitutional violation and that "no other relief" will remedy the violation. 18 U.S.C. § 3626(a)(3)(E). Confusing "necessary" with "sufficient," the State argues that this standard is not met unless eliminating crowding, without more, will entirely cure the constitutional violation. State Br. at 30, 33.

4. After taking extensive evidence, the three-judge court concluded that "California's prisoner population *must* be reduced to some level between 130% and 145% design capacity if the CDCR's medical and mental health services are

ever to attain constitutional compliance." JS1-App. 183a. The court ultimately ordered the State to reduce its prison population to 137.5% of design capacity within two years. The State now argues that this order violates the PLRA because there has been no showing that the Eighth Amendment specifically requires this precise level of population reduction, rather than some slightly different figure, such as 130% or 145% of capacity. State Br. at 42.

5. The PLRA requires that a court considering a prisoner relief order "give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused" by the order. 18 U.S.C. § 3626(a)(1)(A). The three-judge court devoted fifty pages of its opinion to considering the public safety implications of its order. Nevertheless, the State argues that this requirement is not satisfied because the lower court did not credit *the State's opinion* that public safety would be compromised. State Br. at 54. The State thus argues in effect that defendants must have veto power over a court's issuance of a prisoner release order.

6. Finally, the State argues that the PLRA bars a prisoner release order that affects prisoners other than those who are members of the *Plata* and *Coleman* classes – even if such an order is necessary to cure the violation of those class members' Eighth Amendment rights. State Br. at 49-53.

Because it makes prisoner release orders unavailable as a practical matter, acceptance of the State's construction of the PLRA would raise serious concerns under the Constitution as well as the treaty and other international law obligations of the United States.

A. A Construction of the PLRA Under Which Prisoner Release Orders are *De Facto* Unavailable Would Raise Serious Constitutional Questions.

"[W]here constitutional rights are at stake and where Congress leaves the federal courts with authority to grant only plainly inadequate relief, it has set itself against the Constitution." Lawrence G. Sager, *Constitutional Limitations on Congress' Authority to Regulate the Jurisdiction of the Federal Courts*, 95 Harv. L. Rev. 17, 88 (1981). Were the PLRA interpreted to bar a prisoner release order even when necessary to cure an ongoing constitutional violation, serious constitutional questions would be raised.

"The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury." *Marbury v. Madison*, 5 U.S. 137, 163 (1803). Perhaps the most essential remedy is injunctive relief to halt an ongoing violation of constitutional rights. "[I]njunctive relief has long been recognized as the proper means for preventing entities from acting unconstitutionally." *Corr. Servs. Corp. v. Malesko*, 534 U.S. 61, 74 (2001); *see also Bell v. Hood*, 327 U.S. 678, 684 (1946) ("it is established practice for this Court to sustain the jurisdiction of federal courts to issue injunctions to protect rights safeguarded by the Constitution"). *See also Greenya v. George Washington Univ.*, 512 F.2d 556, 562 n.13 (D.C. Cir. 1975) ("If the Constitution creates a right, privilege, or immunity, it of necessity gives the proper party a claim for equitable relief if he can prevail on the merits").

This Court has held that a "'serious constitutional question' . . . would arise if a federal statute were construed to deny any judicial forum for a colorable constitutional claim." *Webster v. Doe*, 486 U.S. 592, 603 (1988); *accord, Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667, 681 n.12 (1986) (noting with approval the view that "all agree that Congress cannot bar all remedies for enforcing federal constitutional rights"). In *Zehner v. Trigg*, 133 F.3d 459 (7th Cir. 1997), the Seventh Circuit considered the constitutionality of the PLRA's limits on damages for prisoners' "mental or emotional injury." *See* 42 U.S.C. § 1997e(e). The Court quoted with approval the district court's observation that "there is a point beyond which Congress may not restrict the availability of judicial remedies for the violations of constitutional rights without in essence taking away the rights themselves," but concluded that the continued availability of injunctive relief rendered the restriction on damages constitutional. 133 F.3d at 462-63. Here, by contrast, it is precisely injunctive relief that the State argues is unavailable to prisoners suffering ongoing Eighth Amendment violations.

"[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust for S. Cal.*, 508 U.S. 602, 628-29 (1993). As demonstrated above, the better construction of the PLRA permits the order entered by the lower court and thus avoids these constitutional doubts.

B. Construing the PLRA to Render Prisoner Release Orders Unavailable Is Inconsistent With Treaty and Other International Law Obligations of the United States.

International law requires that states provide adequate medical care to prisoners including, where appropriate, mental health treatment. Failure to provide prisoners with such care violates both their right to human dignity and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment under international law, and gives rise to an obligation to provide an effective remedy. Consistent with well-settled principles of statutory construction, the PLRA should not be construed to bar a remedy required by international law.

1. International Law Requires that States Provide Adequate Medical and Mental Health Care to Prisoners.

Acknowledging the particular vulnerability of prisoners to abuse, international law affords them special measures of protection. The International Covenant on Civil and Political Rights, a treaty signed and ratified by the United States, requires that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." International Covenant on Civil and Political Rights ("ICCPR"), art. 10(1), Dec. 16, 1966, 6 I.L.M. 368, 999 U.N.T.S. 171. The United Nations Human Rights Committee, tasked with monitoring compliance with the ICCPR, has affirmed the "positive obligation" on states to protect the rights of those whose vulnerability arises from their status as persons deprived of their liberty. Human Rights Committee, General Comment No. 21, article 10, ¶3, U.N. Doc. HRI/GEN/1/Rev.1 at 33 (1994). In furtherance of this obligation, international and regional human rights laws and standards require that states provide prisoners with adequate medical services, including where appropriate mental health treatment.[11]

Three instruments developed by the United Nations set out international human rights standards for the proper treatment of persons deprived of liberty, including their right to receive appropriate medical care, and provide guidance as to how governments may comply with their human rights treaty obligations. The Standard Minimum Rules for the Treatment of Prisoners state that prisons should provide medical services, including psychiatric services, "organized in close relationship to the general health administration of the community or nation" and that "[t]he medical services of an institution shall seek to detect and shall treat any physical or mental illness or defects which may hamper a prisoner's rehabilitation." Standard Minimum Rules for the Treatment of Prisoners ("SMR"), adopted by the First United Nations Congress on the Prevention of Crime and Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, E.S.C. res. 663C, U.N. ESCOR 24th Sess., Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (NO. 1) at 35, U.N. Doc. E/5988 (1977), Rules 22.1, 62.

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[11] *Pinto v. Trinidad and Tobago*, Communication No. 232/1987, ¶ 12.7, U.N. Doc. CCPR/C/39/D/232/1987 (1990) (noting that Article 10(1) requires that governments provide "adequate medical care during detention.")

Similarly, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment states that prisoners are to be given medical screening upon admission and provided appropriate medical care and treatment as necessary. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (no. 49) at 298, U.N. Doc. A/43/49 (1988), Principle 24 (stating "A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary."). Finally, the Basic Principles for the Treatment of Prisoners provide that prisoners should receive a quality of health care comparable to that available in the outside community. Basic Principles for the Treatment of Prisoners, G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (no. 49A) at 200, U.N. Doc. A/45/49, Principle 9 (1990). While these instruments do not impose binding international obligations on the United States, they set forth detailed guidance on the content of treaty standards and customary international law.

The Standard Minimum Rules for the Treatment of Prisoners, adopted by the United Nations "on the basis of the general consensus of contemporary thought and the essential elements of the most adequate systems of today,"[12] also provide detailed guidelines for the proper management and treatment of prisoners with mental disabilities. The SMR set out that psychiatric services should be available at each facility for any prisoner in need thereof,[13] and that prisons be adequately staffed to provide psychiatric services.[14] They provide in addition that prisoners should be individually assessed for mental illness and thereafter categorized and treated in accordance with that assessment.[15]

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[12] SMR, Rule 1.

[13] *Id.*, Rule 22.1 ("At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality."); Rule 82.4 ("The medical or psychiatric service of the penal institutions shall provide for

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the psychiatric treatment of all other prisoners who are in need of such treatment.").

[14] *Id.*, Rule 49.1 ("So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors.").

[15] *Id.*, Rules 22.1, 62. *See also*, International Criminal Tribunal for the former Yugoslavia, Rules Governing the Detention of Persons Awaiting Trial or Appeal before the Tribunal or Otherwise Detained on the Authority of the Tribunal, U.N. Doc. IT/38/REV.9 (Oct. 7, 2005), *available at* http://www.icty.org/x/file/Legal%20Library/Detention/IT38UNDU_rules_rev9_2005_en.pdf, Rule 34(B) ("The medical officer shall have the care of the physical and mental health of detainees and shall see, on a regular basis or as is necessary, all sick detainees, all who complain of illness, and any detainee to whom his attention is specifically directed."). Standards for the treatment of prisoners have also been developed regionally to mirror and expand upon those set by the SMR and other international instruments. *See* European Prison Rules, Council of Europe, Recommendation of the Committee of Ministers to member states, (Jan. 11, 2006), *available at* https://wcd.coe.int/ViewDoc.jsp?id=955747, Rule 40.3 ("Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."), Rule 42.3 ("When examining a prisoner the medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to: ... (b) diagnosing physical or mental illness and taking all measures necessary for its treatment and for the continuation of existing medical treatment ... (e) identifying any psychological or other stress brought on by

2. A State's Failure To Provide Appropriate Medical and Mental Health Care to Prisoners Constitutes Torture or Cruel, Inhuman or Degrading Treatment.

International and regional human rights laws and standards also recognize that a failure on the part of the state to ensure that prisoners are afforded adequate and appropriate medical treatment can constitute cruel, inhuman or degrading treatment, and in certain situations, torture. Article 7 of the ICCPR states that no one "shall be subjected to torture or to other cruel, inhuman or degrading treatment or punishment." The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("CAT"), a treaty signed and ratified by the United States, also prohibits such treatment. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, S. Treaty Doc. No. 100-20, 1465 U.N.T.S. 85. Both the U.N. Human

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the fact of deprivation of liberty."); Rule 47.2 ("The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention."); Rule 81.3 ("Staff who are to work with specific groups of prisoners, such as foreign nationals, women, juveniles or mentally ill prisoners, etc., shall be given specific training for their specialised work."); and Rule 89.1 ("As far as possible, the staff shall include a sufficient number of specialists such as psychiatrists, psychologists, social and welfare workers, teachers and vocational, physical education and sports instructors.").

Rights Committee and the Committee against Torture, which monitors compliance with the CAT, have determined that a failure to provide adequate medical care to prisoners violates the prohibition on cruel, inhuman or degrading treatment and may amount to torture. *Raul Sendic Antonaccio v. Uruguay*, Communication No. R.14/63, U.N. Doc. Supp. No. 40 (A/37/40) at 114 (1982), para. 20; U.N. Committee against Torture, *Concluding Observations: New Zealand*, (1998) U.N. Doc. A/53/44, at para. 20 175.[16] Regional human rights courts, including the Inter-American Court of Human Rights and the European Court of Human Rights, have repeatedly held that the absence of or inadequate medical and mental health treatment for prisoners violates the prohibition of torture and other cruel, inhuman or degrading treatment or punishment.[17]

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[16] *See also*, Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Report of the Special Rapporteur, Mr. P. Kooijmans, E/CN.4/1986/15, para. 119, 19 Feb. 1986, *available at*: http://ap.ohchr.org/documents/E/CHR/report/E-CN_4-1986-15.pdf. (noting that "prolonged denial of medical assistance" may constitute torture.).

[17] *See e.g., Garcia-Asto and Ramirez-Rojas v. Peru*, Inter-Am. Ct. H.R., (Ser C.) No. 137, paras. 225-27 (Nov. 25, 2005) (holding that the lack of adequate medical assistance may constitute torture or cruel, inhuman, or degrading punishment or treatment.); *Montero Aranguren et al. (Detention Center of Catia) v. Venezuela*, 2006 Inter-Am. Ct. H R (ser. C.) No. 150 paras. 101-104 (July 5, 2006) (finding violations of Article 5(1) of the American Convention (right to physical, mental and moral integrity) and 5(2) (right to be free from torture or cruel, inhuman, or degrading

These judicial decisions together with the international laws and standards upon which they are based demonstrate a growing international consensus that prisoners have a right to adequate medical treatment including, where appropriate, mental health services; and that the failure of the state to provide such treatment violates prisoners' human rights to dignity and to be free from torture and other cruel, inhuman or degrading treatment.

3. International Law Requires an Effective Remedy for Cruel, Inhuman, or Degrading Treatment, and the PLRA Should Not be Construed to Bar Such a Remedy.

When a state violates the prohibition on torture or other cruel, inhuman, or degrading treatment or punishment, international law requires that it provide those harmed with an adequate and effective remedy.[18] To implement

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punishment or treatment)); *Slawomir Musial v. Poland*, App. No. 28300/06, Eur Ct. H.R. (2009), para. 86 (finding a violation of the right to be free from torture or cruel or inhuman treatment where the state failed to ensure that prisoners' "health and well-being are adequately secured by, among other things, providing them with the requisite medical assistance."); *Melnik v. Ukraine*, App. No. 72286/01, Eur. Ct. H.R. 50 (2006) paras. 110-112 (finding the Article 3 prohibition of torture and inhuman or degrading treatment or punishment of the European Convention was violated where prisoners were not provided with adequate medical care).

[18] *See* Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948), art. 8 ("Everyone has the right to an

this internationally recognized right to a remedy, governments must open their legal systems to claims by victims of rights violations. "States must adopt appropriate and effective judicial and administrative procedures and other appropriate measures that provide fair, effective, and prompt access to justice" and "afford appropriate remedies to victims."[19]

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effective remedy by the competent national tribunals for acts violating . . . fundamental rights . . . ."); ICCPR, art. 2(3) (requiring that states provide "an effective remedy" including "judicial remedy" for victims of violations of the ICCPR and that states "ensure that the competent authorities shall enforce such remedies when granted."); CAT, art. 14(1) ("Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation . . . ."); *see also*, Human Rights Committee, General Comment 31, Nature of the General Legal Obligation on States Parties to the Covenant, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004) ¶ 15 ("...States Parties must ensure that individuals also have accessible and effective remedies to vindicate those rights [protected by the ICCPR]").

[19] U.N. Commission on Human Rights, The Right to Restitution, Compensation and Rehabilitation for Victims of Grave Violations of Human Rights and Fundamental Freedoms, Final Report of the Special Rapporteur, M. Cherif Bassiouni, U.N. ESCOR, 56th Sess., at XX 2(b), 2(c), 3(d), U.N. Doc.E.CN.4/2000/62. *See generally* Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, G.A. Res 60/147, U.N. Doc. A/RES/60/147 (Dec. 16, 2005) (discussing the internationally protected right to substantive and procedural remedies, including equal and effective access to justice).

The PLRA's limitations on remedies for prisoners raise serious concerns under these principles. Indeed, the Committee against Torture, in its most recent review of the United States, recognized that the PLRA's limitation on remedies for mental or emotional injury contravenes Art. 14 of the CAT (requiring redress for victims of torture) and called for its repeal.[20]

In this case, the lower court found that a prisoner release order is the only effective means of remedying ongoing deficiencies in medical and mental health care that violate the Eighth Amendment and therefore presumptively violate international law. *See Estelle v. Gamble*, 429 U.S. 97, 103 n. 8 (1976) (citing Rules 22-26 of the SMR as reflective of the "contemporary standards of decency" that guide Eighth Amendment analysis).[21] But the State argues for a construction of the PLRA that would bar a prisoner release order in this case and make such orders unavailable as a practical matter. Such a construction is inconsistent with the treaty and other international law obligations of the United

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[20] Committee against Torture, *Consideration of Reports Submitted by States Parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee against Torture, United States of America*, ¶29, CAT/C/USA/CO/2 (May 18, 2006), *available at* http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/c2d4f5b2dccc0a4cc12571ee00290ce0/$FILE/G0643225.pdf.

[21] *Cf. Graham v. Florida*, 130 S.Ct. 2011, 2033-34 (2010) (citing international law, including U.S. treaty obligations, as "support" for holding that juvenile life without parole for non-homicide offenses violates the Eighth Amendment).

States, and under well-established principles of statutory construction, is to be avoided if possible. *See Murray v. The Charming Betsy*, 6 U.S. (2 Cranch) 64 (1804) ("It has also been observed that an act of Congress ought never to be construed to violate the law of nations if any other possible construction remains..."). As explained above, the better construction is that the PLRA poses no obstacle to a prisoner release order in this case.[22]

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[22] *The Charming Betsy* doctrine is a long-standing doctrine of statutory construction that this Court has affirmed in numerous decisions. *See, e.g., Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993); *Sale v. Haitian Centers Council, Inc.*, 509 U.S. 155, 178 n.35 (1993); *Lauritzen v. Larsen*, 345 U.S. 571, 578 (1953).

CONCLUSION

For the reasons set forth above, the order of the lower court should be affirmed.

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Oct. 28, 2010

APPENDIX

INTEREST OF *AMICI*

The *American Civil Liberties Union* (ACLU) is a nationwide, non-profit, non-partisan organization with over 500,000 members dedicated to the principles of liberty and equality embodied in the Constitution and this nation's civil rights laws. The *ACLU of Northern California, ACLU of Southern California,* and *ACLU of San Diego and Imperial Counties* are its California affiliates. Throughout its 90-year history, the ACLU has been deeply involved in protecting the rights of prisoners, and in 1972 created the National Prison Project to further this work. The ACLU has appeared before this Court in numerous cases involving the rights of prisoners, both as direct counsel and as *amicus curiae*.

Human Rights Watch is a non-profit, independent organization and the largest international human rights organization based in the United States. For over 30 years, Human Rights Watch has investigated and exposed human rights violations and challenged governments to protect the human rights of all persons, including prisoners. Human Rights Watch investigates allegations of human rights violations in the United States and over 80 countries throughout the world by interviewing victims and witnesses, gathering information from governmental and other sources, and issuing detailed reports. Where human rights violations have been found, Human Rights Watch advocates for the enforcement of those rights before government officials and in the court of public opinion.

The *Leadership Conference on Civil and Human Rights* is the nation's oldest and largest civil and human rights coalition, consisting of more than 200 national organizations. The mission of the Leadership Conference is to promote and protect the civil and human rights of all persons in the United States. Access to needed medical and mental health care is a fundamental civil and human right, but the horrific overcrowding in the California state prison system denies this right to one of the most vulnerable segments of society, prison inmates suffering from physical and mental illnesses, with tragic and often fatal consequences. In order to advance its mission, the Leadership Conference supports the authority of the federal courts to issue a prisoner release order as a remedy in extreme circumstances such as these, and has a vital interest in the outcome of this case.

Penal Reform International/The Americas is an affiliate of *Penal Reform International* (PRI), an international non-governmental organization working on penal and criminal justice reform worldwide, with programs in the Great Lakes region of Africa, the Middle East and North Africa, Central and Eastern Europe, Central Asia, the South Caucasus, and North America. PRI seeks to promote the development and implementation of international human rights norms in relation to law enforcement and prison conditions; a reduction in the use of imprisonment throughout the world; and the use of constructive non-custodial sanctions that support the social reintegration of offenders while taking into account the interests of victims.

AMICUS
CURIAE
BRIEF

No. 09-1233

IN THE

Supreme Court of the United States

ARNOLD SCHWARZENEGGER, GOVERNOR
OF THE STATE OF CALIFORNIA, ET AL.,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, ET AL.,
Appellees.

**On Appeal from the
United States District Courts for the
Eastern and Northern Districts of California**

BRIEF OFAMERICAN PSYCHIATRIC ASSOCIATION, CALIFORNIA PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, CALIFORNIA PSYCHOLOGICAL ASSOCIATION, AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, FORENSIC MENTAL HEALTH ASSOCIATION OF CALIFORNIA, NATIONAL ALLIANCE ON MENTAL ILLNESS, AND NAMI-CALIFORNIA AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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INTEREST OF *AMICI CURIAE*[1]

The American Psychiatric Association, with more than 36,000 members, is the Nation's leading organization of physicians who specialize in psychiatry.

The California Psychiatric Association is a nonprofit corporation whose member psychiatrists are medical doctors specializing in the comprehensive care of adults and children with mental and emotional disorders that stem from biological and psychosocial causes, including those with drug and other addictions. The Association is dedicated to the prevention and treatment of mental disorders; to the furtherance of psychiatric education and research; and to the furtherance of psychiatric procedures for the public welfare.

The American Psychological Association is a nonprofit professional organization founded in 1892. The Association has approximately 150,000 members, including the majority of psychologists holding doctoral degrees from accredited universities in this country. Among the Association's major purposes is to increase and disseminate knowledge regarding human behavior and to foster the application of psychology to important human concerns.

The California Psychological Association ("CPA"), incorporated in 1948, has 4,000 members and is the largest state psychological association in the United States. The members of CPA represent licensed psychologists from all areas of psychology including clinical practice, public service, teaching, and research. The mission of CPA is to strengthen, promote, and sustain the discipline and practice of psychology.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel for *amici* also represent that all parties have consented to the filing of this brief, and a letter reflecting their blanket consent to the filing of *amicus* briefs has been filed with the Clerk.

The American Academy of Psychiatry and the Law, with approximately 2,000 psychiatrist members, is an organization of psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry, a subspecialty recognized by the Accreditation Council of Graduate Medical Education. The Academy sponsors numerous educational activities and programs and is engaged in the development of professional and ethical standards of practice for forensic psychiatrists.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities. The Center has engaged in litigation, policy advocacy, and public education to preserve the civil rights of and promote equal opportunities for individuals with mental disabilities in institutional as well as community settings. It has litigated numerous cases concerning the rights of people with mental illness in correctional facilities.

The Forensic Mental Health Association of California ("FMHAC") is a non-profit membership association that provides support and education to forensic mental health and criminal justice professionals. FMHAC's objectives are to foster the provision of effective mental health services to persons in the criminal justice system; assist mental health and criminal justice professionals, as well as the public, to understand the nature of forensic mental health services; and to enhance the quality of forensic mental health evaluation, diagnosis, and treatment.

The National Alliance on Mental Illness ("NAMI") is the Nation's largest grassroots organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has a long history of advocating for policies and programs both to prevent the unnecessary incarceration of people living with serious mental illness and to facilitate better services for persons with these illnesses during incarceration and following discharge.

NAMI-California is the largest grassroots organization of families and individuals whose lives are affected by serious mental illness in California. Comprised of 71 affiliates, NAMI-California provides leadership in advocacy, legislation, policy development, education, and support throughout the State.

These organizations have participated in numerous cases in this Court. They and their members have a strong interest in correctional mental health care and longstanding commitments to ensuring that jail and prison inmates with mental illness have access to adequate care. *See, e.g.*, American Psychiatric Ass'n, Position Statement, *Psychiatric Services in Jails and Prisons*, APA Doc. No. 198804 (1988), *available at* http://archive.psych.org/edu/other_res/lib_archives/archives/198804.pdf. That commitment includes a realistic recognition that severe overcrowding may render the provision of even minimally adequate care – a civil right guaranteed to inmates under the Constitution – impracticable.

SUMMARY OF ARGUMENT

The three-judge district court, applying defendants' proposed standard, found that overcrowding in California's prisons was the primary cause of the State's failure to deliver constitutionally adequate mental health care to its prison inmates and that no relief other than a reduction in overcrowding would address the constitutional violations. *See* JS1-App.[2] 78a, 168a. Those findings – which come after nearly two decades of litigation and unavailing remedial efforts – are consistent with the clinical experience of professionals with expertise in correctional mental health care and the scientific literature.

I. "A prison official's deliberate indifference' to a substantial risk of serious harm to an inmate violates the Eighth Amendment." *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). That standard requires prison officials to "ensure that inmates receive . . . medical care," including mental health care. *Id.* at 832; *see Clark-Murphy v. Foreback*, 439 F.3d 280, 292 (6th Cir. 2006). Early in this litigation, the *Coleman* court found – without objection from defendants – that there are "six basic, essentially common sense, components of a minimally adequate prison mental health care delivery system." *Coleman v. Wilson*, 912 F. Supp. 1282, 1298, 1301 (E.D. Cal. 1995). Those components include (1) screening and evaluating inmates; (2) a treatment program; (3) adequate staffing; (4) maintenance of adequate records; (5) administration of medication only with appropriate supervision and periodic evaluation; and (6) a program for suicide prevention. *Id.* at 1298 n.10. Experts on correctional mental health have identified additional important or desirable components of a correctional mental health care program, but there is no dispute that inmates with mental illness are at serious risk of suffering "unnecessary and wanton infliction of pain," *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (internal quotation marks omitted), if those minimum requirements are not met.

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[2] References to "JS1-App." are to the appendix accompanying the jurisdictional statement in No. 09-416.

II. A. The nature of what is required for minimally adequate mental health care reinforces the three-judge district court's finding that "crowding creates numerous barriers to the provision of medical and mental health care that result in the constitutional violations we consider here." JS1-App. 80a-81a. To conduct adequate initial screenings and subsequent evaluations requires sufficient staff and adequate physical space to ensure confidentiality. Provision of appropriate treatment for mentally ill inmates likewise requires staff and facilities – including a sufficient number of inpatient beds. Crowding that far outstrips the capacity of available mental health care professionals and facilities may make delivery of minimally adequate care impracticable. Management of medications and provision of other therapies – critical to ensure that mentally ill inmates do not needlessly suffer the effects of untreated illnesses – may become infeasible in a prison system characterized by overcrowding and frequent prisoner transfers. Overcrowding both increases the importance of medical records – because of frequent patient transfers and high turnover of clinical staff – and exacerbates weaknesses in medical record systems. And a prompt and effective response to indications that inmates may be at risk of suicide requires adequate crisis beds and effective staff supervision. The testimony of experienced experts in correctional mental health care documented all of these impacts of overcrowding, providing the factual underpinnings for the three-judge district court's "primary cause" and "no other relief" holdings.

B. Expert testimony that overcrowding can exacerbate inmates' existing mental illness or induce mental illness in vulnerable inmates is consistent with the literature relating to the psychological and behavioral effects of overcrowding. Prison crowding is associated with negative outcomes and contributes to conditions of confinement – including high stress, sleep deprivation, and enforced idleness – that may cause or exacerbate mental illness and increase the risk of inmate suicide.

ARGUMENT

There are vast numbers of individuals with serious mental illness in correctional facilities in the United States. In 1995, when the district court in *Coleman* first determined, after five years of litigation, that the provision of mental health care in California's prisons failed to meet constitutional minimum standards, it was estimated that there were "between 13,000 and 18,000 inmates in California's prisons in need of treatment because they suffer from serious mental disorders." *Coleman v. Wilson*, 912 F. Supp. at 1299. By mid-2008, that number had approximately doubled, with the State reporting that more than 34,000 of the approximately 160,000 inmates in California's prisons suffered from serious mental illness requiring intervention.[3] The dramatic increase in mentally ill inmates in California's prisons is paralleled by comparable increases nationwide. At mid-year 2005, more than 1.25 million individuals in custody — more than half of the total population of the Nation's prisons and jails — had a symptom of mental illness.[4] That number exceeds the total population of the Nation's prisons and jails as recently as 1990.[5] "Studies and clinical experience have consistently indicated that 8 to 19 percent of prisoners have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration."[6]

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[3] *See* JS1 App. 31a (citing CDCR mental health population placement reports).

As demand for mental health care services in correctional facilities has dramatically grown, mental health professionals have developed guidelines to assist correctional officials and mental health care professionals in the provision of adequate mental health care in prisons and jails.[7] The basic elements of a minimally adequate mental health care program, as laid out in the professional literature, are consistent with lower court decisions and with the uncontested findings in this case.[8] Those sources recognize the distinction between essential requirements for minimally adequate care and those standards that are fairly characterized as important or desirable.[9] That literature and those standards thus provide an appropriate framework for evaluating, in light of the record evidence, the three-judge district court's determinations that overcrowding is the primary

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[4] *See* Doris J. James & Lauren E. Glaze, U.S. Dep't of Justice, *Mental Health Problems of Prison and Jail Inmates* 1 (Sept. 2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf; *see also* Humberto Temporini, *Conducting Mental Health Assessments in Correctional Settings*, *in Handbook of Correctional Mental Health* 119, 120-28 (Charles L. Scott ed., 2d ed. 2010) ("Scott *Handbook*") (reviewing data concerning prevalence of mental illness among inmates).

[5] *See* Darrell K. Gilliard & Allen J. Beck, U.S. Dep't of Justice, *Prison and Jail Inmates at Midyear 1996*, Table 2 (Jan. 1997), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/pjimy96.pdf.

[6] Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry: Part I*, 25 J. Am. Acad. Psychiatry L. 375, 375 (1997) ("Metzner, *Correctional Psychiatry: Part I*").

[7] *See, e.g.*, Scott *Handbook*, *supra*; National Comm'n on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (2008) ("NCCHC *Standards*"); American Psychiatric Ass'n, *Psychiatric Services in Jails and Prisons* (2d

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[8] *See Coleman v. Wilson*, 912 F. Supp. at 1298 (citing *Balla v. Idaho State Bd. of Corrections*, 595 F Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980)); *see also, e.g.*, *Wellman v. Faulkner*, 715 F.2d 269, 272-73 (7th Cir. 1983); *Ginest v Board of County Comm'rs*, 333 F. Supp. 2d 1190, 1200 (D. Wyo. 2004); *Morales Feliciano v. Rosselló González*, 13 F. Supp. 2d 151, 208-12 (D.P.R. 1998); *Madrid v. Gomez*, 889 F. Supp. 1146, 1214-27 (N.D. Cal. 1995); *Tillery v. Owens*, 719 F. Supp. 1256, 1302-03 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3d Cir. 1990); *see also* Metzner, *Correctional Psychiatry: Part III*, 26 J. Am. Acad. Psychiatry L. at 107 (mental health care treatment in a correctional setting should "alleviate symptoms of mental disorders that significantly interfere with an inmate's ability to function in a particular criminal justice environment" and, "as in the community, should also be available for purposes of alleviating symptoms of mental disorder associated with present distress . . . or with a significantly increased risk of suffering death, pain, or significant impairment").

[9] *See generally* NCCHC *Standards*, *supra* (distinguishing between standards that are "essential" and those that are "important").

cause of the constitutional violations and that no other relief would remedy the constitutional violations.

I. THE ELEMENTS OF A MINIMALLY ADEQUATE CORRECTIONAL MENTAL HEALTH CARE PROGRAM PROVIDE THE APPROPRIATE FRAMEWORK IN WHICH TO EVALUATE THE THREE-JUDGE DISTRICT COURT'S FINDINGS

The legal standards governing the claims of the *Coleman* class are settled and are not at issue in this appeal. Nevertheless, they help to provide the framework in which the three-judge district court's findings should be reviewed.

In *Estelle v. Gamble*, this Court held that Eighth Amendment principles "establish the government's obligation to provide medical care for those whom it is punishing by incarceration." 429 U.S. at 103. That obligation "extend[s] . . . beyond the Eighth Amendment setting": the Fourteenth Amendment's Due Process Clause requires the State to provide involuntarily committed mental patients with adequate "'food, shelter, clothing, and medical care.'" *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 199 (1989) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982)). As then-Chief Justice Rehnquist explained, "when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs" – including "medical care" – "it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause." *DeShaney*, 489 U.S. at 200.

The constitutional obligation to provide adequate medical care includes, of course, the obligation to provide adequate mental health care. *See, e.g.*, *Clark-Murphy*, 439 F.3d at 292; *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (Tjoflat, C.J.); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) ("We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."). The parties agreed, and the *Coleman* court held, that a minimally adequate mental health treatment program includes "six basic, essentially common sense, components." *Coleman v. Wilson*, 912 F. Supp. at 1298 & n.10. Each of these components has been the subject of standard-setting efforts by mental health care professionals and correctional experts.

"First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment." *Ruiz v. Estelle*, 503 F. Supp. at 1339. That initial screen has "multiple purposes": identifying inmates with severe mental illness who may require immediate attention; preventing inmate suicides; providing a foundation for continuation of care including, for example, existing medications; and preliminary identification of mental health problems that may require further assessment.[10] In addition, inmates may develop mental illness while in custody, which must be detected and treated. Second, there must be a program for provision of treatment to mentally ill inmates that "entail[s] more than segregation and close supervision." *Id.* Third, there must be a sufficient number of competent mental health care professionals – *i.e.*, adequate staffing – "to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders." *Id.*

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[10] Temporini *in* Scott *Handbook* at 130; *see* APA *Psychiatric Services* at 39-45 (reviewing "[e]ssential [s]ervices" associated with mental health screening and referral and mental health evaluations); NCCHC *Standards* at 52-57 (characterizing mental health screening and evaluation as "essential").

"Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained." *Id.* The inmate's medical record should reflect current evaluation and management of an inmate's illnesses and allow the tracking of the course of an illness over time, including response to therapy.[11] An accurate and complete medical record may take on special importance in the correctional context because of frequent inmate movements and high turnover of medical and mental health professional staff. Fifth, psychotropic medication should be administered "with appropriate supervision and periodic evaluation." *Coleman v. Wilson*, 912 F. Supp. at 1298 n.10.[12] "Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program." *Ruiz v. Estelle*, 503 F. Supp. at 1339.[13]

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[11] *See* Amanda Ruiz, *Continuous Quality Improvement and Documentation*, *in* Scott *Handbook* 149, 158-63; NCCHC *Standards* at 89-92 (essential standards related to medical records management).

[12] *See generally* Kathryn A. Burns, *Pharmacotherapy in Correctional Settings*, *in* Scott *Handbook* 321, 321 ("Psychotropic medication is the medically accepted standard of care or treatment of choice for certain of the serious mental illnesses."). Proper administration is essential, because medications can have serious side effects; patients also may suffer harm if needed medications are withdrawn precipitously. *See, e.g.*, *id.* at 330-43; NCCHC *Standards* at 34.

The state government *amici* argue that the three-judge district court failed to rely on "objective measures of community expectations for prison health care," suggesting that the deficiencies found by the court lack constitutional significance. Louisiana et al. *Amicus* Br. 18. That claim ignores both the procedural history of the *Coleman* litigation and the established standard for minimally adequate correctional mental health care. As noted above, the standard for minimally adequate mental health care that the *Coleman* court applied was drawn from settled federal court precedent and *was not contested by the State*. *See Coleman v. Wilson*, 912 F. Supp. at 1301. The elements of a minimally adequate mental health care program are precisely those that are required to prevent "further significant injury or the 'unnecessary and wanton infliction of pain'" – as the Constitution requires. *Id.* at 1298 (quoting *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992)). California's liability for failing to establish a minimally adequate mental health care program under this standard was first adjudicated 15 years ago, and the State has never moved to vacate that determination.

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[13] Consistent with national correctional standards, a comprehensive suicide prevention policy should include staff training; intake screening and assessment; communication with the inmate and among law enforcement, correctional staff, and medical personnel; appropriate housing for suicidal inmates; adequate observation; intervention when inmates attempt self-injury; reporting; and morbidity-mortality review. *See* Lindsay M. Hayes, *Toward a Better Understanding of Suicide Prevention in Correctional Facilities*, *in* Scott *Handbook* 231, 236-45; APA *Psychiatric Services* at 14-15

The question is not and never has been what sort of mental health care program that correctional mental health experts should, ideally, put in place.[14] Rather, the issue always has been ensuring that the "basic human needs" of prison inmates are met, *DeShaney*, 489 U.S. at 200, recognizing that, while "[t]he Constitution does not mandate comfortable prisons, . . . neither does it permit inhumane ones," *Farmer v. Brennan*, 511 U.S. at 833 (internal quotation marks omitted).

II. THE THREE-JUDGE DISTRICT COURT'S DETERMINATIONS THAT CROWDING IS THE PRIMARY CAUSE OF THE DENIAL OF MINIMALLY ADEQUATE MENTAL HEALTH CARE AND THAT NO OTHER RELIEF WOULD REMEDY THE VIOLATIONS ARE CONSISTENT WITH CLINICAL EXPERIENCE

The three-judge district court determined that "crowding creates numerous barriers to the provision of medical and mental health care . . . includ[ing] severe space and other shortages"; that "[c]rowding also renders the state incapable of maintaining an adequate staff and an adequate medical records system"; and that "crowding causes prisons to rely on lockdowns, which further restrict inmates' access to care." JS1-App. 80a-81a. The court also found that overcrowding creates conditions of confinement that, themselves, "increase the incidence and severity of mental illness among prisoners." *Id.* at 81a. Applying defendants' proposed definition of "primary cause" – *i.e.*, "the cause that is 'first or highest in rank or importance; chief; principal,'" *id.* at 78a – the court "conclude[d] that clear and convincing evidence establishes that crowding is the primary cause of the unconstitutional denial of medical and mental health care to California's prisoners." *Id.* at 82a.

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[14] *See, e.g.*, 1 Fred Cohen, *The Mentally Disordered Inmate and the Law* ¶ 2.6[1], [2] (2d ed. 2008) (distinguishing between minimal components and desirable components of a mental health care treatment program).

The three-judge district court had before it an extensive record documenting the effects of crowding on the provision of medical care generally and mental health care in particular. Any comprehensive review of that factual record is beyond the scope of this brief. Nevertheless, the nature of what is required to ensure the provision of minimally adequate mental health care and the scientific literature on the psychological and behavioral effects of overcrowding support the court's "primary cause" and "no other relief" determinations with regard to the *Coleman* class.

A. Overcrowding May Seriously Obstruct the Provision of Minimally Adequate Care

Clinical experience supports the conclusion that crowding may create pervasive and intractable problems for the provision of minimally adequate mental health care. To ensure that prisoners are evaluated for mental illness and afforded minimally adequate treatment, there must be sufficient clinical staff, space in which to provide treatment and perform screening and clinical evaluations, and clinical facilities to accommodate inmates requiring higher levels of care. Accordingly, where prisons are severely overcrowded, mental health care resources can be overwhelmed. There is extensive record evidence that overcrowding has had this effect in California's prisons, with impacts on each of the six components of minimally adequate care.

Deficiencies in Screening and Evaluation: The large number of inmates entering the California prison system and rapid turnover make screening for mental illness and evaluation of new and returning inmates critical to ensuring that mentally ill inmates are appropriately housed and treated. The evidence supports the conclusion that burdens on staff and facilities have complicated initial screening and mental health evaluation. For example, there was testimony that there was inadequate office and treatment space in certain facilities – and inadequate correctional staff – to allow for initial evaluation of inmates in a confidential setting.[15]

Deficiencies in Treatment: The record indicated that, because of crowding, California's prisons could not adequately treat prisoners in need of higher levels of mental health care nor could they adequately treat inmates with less severe mental health needs who were housed in the general population.

The delivery of mental health care in California's prisons is organized around a system of classifying individuals by the severity of their mental illness.

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[15] Expert Report of Pablo Stewart, M.D., *Coleman* Docket Entry 3217, at 48 ("Stewart Report") ("[i]n my opinion, this is a dangerous practice"); *see also id.* at 32 ("Lack of adequate and appropriate space for reception center psychological screening was . . . apparent at [Deuel Vocational Institute ("DVI")]."); Expert Report of Professor Craig Haney, *Coleman* Docket Entry 3201, at 77 ("Haney Report") (describing lack of facilities for confidential screening of prisoners at Valley State Prison for Women). The insufficiency of appropriate physical space – that is, private enough to allow for confidential screening, evaluation, and treatment – cannot be addressed by hiring additional staff and may effectively limit the capacity to increase staff.

At the lowest level are Correctional Clinical Case Management Services ("CCCMS") inmates, who are housed in the general prison population. *See* JS1-App. 42a-43a & n.25. Enhanced Outpatient Program ("EOP") inmates are those who suffer "Acute Onset or Significant Decompensation of a serious mental disorder," who cannot function in the general inmate population, but who do not require round-the-clock nursing care or hospitalization. *Id.* at 43a & n.24. Mental Health Crisis Beds ("MHCBs") are for inmates who are "markedly impaired and/or dangerous to others as a result of mental illness, or who are suicidal, and who require 24-hour nursing care." *Id.* Department of Mental Health ("DMH") Inpatient Hospital Care is for inmates who cannot be treated at a lower level of care. *Id.*[16]

There is no dispute that the State lacks facilities to accommodate mentally ill inmates who require higher levels of care.[17] As a result, mentally ill inmates cannot be transferred to appropriate levels of care in compliance with court-ordered timeframes.[18] There is evidence that, due to the lack of sufficient numbers of MHCBs, suicidal and acutely mentally ill patients are housed in administrative segregation units[19] or, during the day, in "dry cells" – that is, small upright

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[16] *See also* Mental Health Services Delivery System Program Guide (rev. Jan. 2006), Ex. P9. at 12-1-4 to 12-1-8 ("Program Guide") (describing treatment criteria for levels of care).

[17] *See* Special Master's Response to Court's May 17, 2007 Request for Information, Ex. D1292, at 9 ("Special Master's May 31 Report") ("[N]early 12 years after the determination that mental health services in [California's prisons] were egregiously unconstitutional, hundreds certainly, and possibly thousands, of . . . inmates/patients . . . are still looking for beds at the level of treatment their mental illness requires."); Expert Report of Ira K. Packer, Ph.D., Ex. D1019, at 8 ("Packer Report") (opinion of defendants' expert: "the lack of adequate intensive mental health treatment beds . . . is the primary cause of the deficiencies in providing mental health care to mentally ill inmates in" California's prisons); Stewart Report at 25 ("[T]he level of acuity among mentally ill inmates at the EOP level of care was extraordinarily high."). 26 ("psychiatrically decompensating suicidal inmates are frequently housed in makeshift holding cells for long periods of time" because of lack of MHCBs), 35 (clinicians

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at DVI reception center "are almost never able to transfer inmates needing higher levels of care to an MHCB unit or to one of the DMH inpatient programs"), 58 (noting that "the waiting list for access to DMH inpatient care programs" at one prison "is currently 111 cases"); Supplemental Expert Report of Pablo Stewart, M.D., *Coleman* Docket Entry 3221, at 35 ("Stewart Supplemental Report") ("Perhaps the most disturbing and direct result of severe overcrowding is the terrible shortage of inpatient beds for *Coleman* class members.").

[18] *See* Program Guide at 12-1-13 (setting out required transfer timeframes); Stewart Report at 64-65 ("Defendants do not appear to be meeting any of these transfer timeframes."); Haney Report at 197-200.

[19] "In administrative segregation units and supermaximum security facilities, prisoners are confined to their cells, by themselves or with cellmates, nearly 24 hours per day. They eat meals in their cells, and their out-of-cell activities are limited to solitary trips to a small yard for recreation." Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, Crim. Just & Behav. OnLineFirst, July 21, 2009, at 2, *available at* http://www.aclu.org/images/asset_upload_file359_41136.pdf.

Mental health experts who have studied the effects of administrative segregation, segregated housing unit placements, and other forms of segregation on inmates with serious mental illnesses have concluded that the social deprivation, idleness, and isolation of these facilities tend to make psychiatric conditions and prognoses worse. *See* Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 Int'l J.L. & Psychiatry 49 (1986).

cages surrounded by wire mesh.[20] More generally, plaintiffs' expert – Dr. Pablo Stewart, a clinical and forensic psychiatrist with 25 years of correctional mental health care experience – gave his opinion that "insufficient access to higher levels of care has created a system which is overwhelmed by the acuity of its patients at every level of care."[21] In his opinion, "[b]y denying prompt access to inpatient care, the State is allowing patients to become more acutely ill than they otherwise would."[22] As a result, the demand for acute care is increased, and patients require treatment for longer periods of time, further exacerbating the shortage of facilities.[23]

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[20] *See, e.g.*, Stewart Report at 26 (due to lack of space, "DVI often houses suicidal inmates in its administrative segregation unit"), 59-60 (describing use of "non-authorized, unlicensed 'treatment settings,'" including dry cells, in Salinas Valley State Prison); Stewart Supplemental Report at 25 (describing inmates "wearing nothing but suicide smocks" with "no mattress or blanket" housed in "small, concrete rooms" that were "completely bare aside from a small toilet and sink" at Mule Creek State Prison); *see also id.* at 24 (describing staff decision to "involuntarily medicate patients[] rather than refer them to an inpatient bed"); Packer Report at 12 (stating that use of upright cages to house mentally ill prisoners "is clearly not an acceptable standard of practice").

[21] Stewart Supplemental Report at 18; *see id.* ("EOP units house many patients in need of inpatient care, MHCB's house patients in need of inpatient hospitalization, intermediate care facility units house many patients in need of acute hospital care, and so on.").

[22] *Id.* at 4.

[23] *See* Special Master's May 31 Report at 9-10 ("The failure to stabilize [inmates requiring mental health care crisis intervention] means more of them will eventually need to be referred for inpatient care, and the unmet needs spiral higher and higher. . . . [I]ncreasing numbers of truly psychotic inmate/patients are trapped in EOPs that cannot meet their needs.").

The three-judge district court also had before it evidence that overcrowding obstructed delivery of appropriate care to CCCMS inmates housed in the general population. Individual and group therapies may be essential for the treatment of many patients with severe psychiatric disorders,[24] but such treatment cannot be delivered without adequate clinical space, qualified mental health care providers, and correctional staff to escort inmates to appointments. For example, in the California Medical Facility ("CMF"), there was evidence that, because available spaces had been converted to dorm housing, "mental health assessments, case manager contacts and psychiatrist meetings are frequently done in non-confidential settings where other staff members and even other inmates may be around."[25] Defendants' expert noted "significant problems in delivering services to CCCMS patients" in Salinas Valley State Prison where "very frequent lockdowns . . . prevent[]

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[24] *See generally* Shama B. Chaiken & Catherine Prudhomme, *Creating Wellness Through Collaborative Mental Health Interventions*, *in* Scott *Handbook* 345.

[25] Stewart Supplemental Report at 22; *see* Stewart Report at 32 ("[D]ue to space limitations, much of the treatment provided to caseload inmates in administrative segregation [at DVI] is provided at cell-front, through the cell door, which is both non-confidential and not conducive to meaningful assessments or meaningful therapy."; "Lack of adequate and appropriate space for reception center psychological screening was also apparent at DVI."), 82 ("[T]he lack of space means that case manager contacts and even therapy contacts take place in [a] public setting that affords no confidentiality."); Haney Report at 109 ("much of what goes on in the treatment area is completely visible to the prisoners in the unit").

group[] [therapy sessions] from occurring . . . [which] makes them almost useless."[26]

Staffing Problems: There was evidence before the three-judge district court that facilities throughout the California prison system have experienced chronic staffing shortages.[27] The lack of clinical and office space has exacerbated the difficulty of recruiting and retaining clinical staff.[28] Also, shortages of custodial staff likewise can impact the ability of the State to deliver adequate care: as defendants' expert explained, shortages of custodial staff – which is "primarily a function of the census," *i.e.*, overcrowding – have "more of an impact on CCCMS inmates, who are housed in General Population and may experience difficulties in movement (to yard and to appointments, as well as to groups)."[29]

Medical Record Deficiencies: Maintaining adequate medical records may become impracticable in an overcrowded facility, with potentially serious impact on clinicians' ability to deliver effective care. The inadequacies of the medical records systems in California prisons, and the deleterious effects on care, were the subject of expert testimony and other evidence.

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[26] Packer Report at 15; *see id.* at 16 ("It is clear . . . that the current situation does impede mental health care in this and similar settings.").

[27] *See* Haney Report at 178-79; Stewart Supplemental Report at 5 ("Until overcrowding is reduced, the State will be unable to hire and retain adequate, qualified and permanent staff.").

[28] *See* Stewart Report at 18; Haney Report at 180 ("In my opinion, the serious deficiencies in office and treatment spaces I observed throughout the system are themselves an obstacle to ever achieving appropriate clinical staffing. The working conditions are terrible and there is no space, in any event, for more clinicians.").

[29] Packer Report at 15.

The *Coleman* Special Master noted concerns about management of medical records in several prisons.[30] At one prison, "staff . . . estimated that about one-third of the time when they meet with patients, they do not have access to the inmate's medical record."[31] Clinical practitioners would agree with the assertion of Dr. Stewart that "[a]ccurate and well organized medical records are a critical element of medical and mental health care" and may become "even more essential in a complex and overcrowded system . . . which is characterized by frequent transfers of patients, high turnover of clinical staff and overuse of contract clinicians who lack familiarity with the patients and the system."[32] Defendants' expert agreed, noting that "[i]n several institutions there were difficulties in clinical staff obtaining charts in a timely manner. . . . In my opinion, this is a direct effect of overcrowding."[33]

Deficiencies in Administration of Medication: Proper administration and monitoring of psychotropic medications is a critical element of appropriate psychiatric care.[34] When inmate populations exceed the capacity of clinical staff to administer and monitor medication, this prevents evaluation of the effectiveness of treatment, poses a danger of undetected side effects, and increases the risk of non-compliance with medication regimes.[35]

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[30] 20th Special Master Report, Ex. D1112, at 68, 120, 154, 169, 176, 200-01, 221, 232, 258, 314.

[31] Stewart Report at 37; *see id.* (discussing DVI: "[t]his is a dangerous clinical situation because staff does not have access to the patient's entire medical and mental health history, including such critical information as drug allergies, prior diagnoses and treatment history"); Haney Report at 58 (noting that, at [the California Institute for Men], "although prisoners typically receive mental health and medical screening within a week of arriving at the prison, this is done without access to medical records, which may not arrive for another several weeks").

[32] Stewart Supplemental Report at 50; *see also supra* note 11.

[33] Packer Report at 19.

The evidence before the three-judge district court addressed deficiencies in medication administration in California prisons. Dr. Stewart concluded that "[t]he medication management system is overwhelmed and the State is therefore unable to adequately monitor both the efficacy and the side effects of prescribed medications."[36] There was evidence that security concerns and workload burdens led correctional personnel to administer medications at cell-front through a food port, a waist-high slot in a solid door that is just large enough to slide in a food tray. When medication is dispensed through food ports, all communication happens through the door (or through the slot if both people bend down) in front of other inmates, eliminating the opportunity to monitor for side effects and the efficacy of medication, and rendering compliance more uncertain.[37]

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[34] *See* APA *Psychiatric Services* at 45-46.

[35] *See* Burns *in* Scott *Handbook* at 322 (for proper use of psychotropic medication, "facility [must] have appropriately trained staff in sufficient numbers to periodically monitor clinical response and potential side effects"), 325 ("Effectiveness of psychotropic medication is difficult, if not impossible, to assess unless the patient has been 100% compliant with taking all doses of the medication as prescribed.").

[36] Stewart Supplemental Report at 4; *see also* 18th Special Master Report, Ex. D1110, at 96-97 (finding deficiencies in medication practices at DVI, including low medication compliance rates), 148 (noting that Salinas Valley State Prison "did not appear to have a functioning mechanism to manage medication"); Stewart Report at 37 ("[N]o effort is currently being made on the part of the medication dispensers [at DVI] to monitor to any degree the clinical efficacy of a given medication."), 48-49 ("In light of the infrequent appointments with psychiatrists and the very brief interactions between patients and staff in the pill lines, Solano [prison] cannot adequately monitor the efficacy of medications, medication side effects, or patient compliance with medications as effectively as necessary."); Stewart Supplemental Report at 20 ("[M]edications [at CMF] were distributed very quickly by line staff who never asked about either the efficacy of the medication or potential side effects.").

Deficiencies in Management of Suicidality: Related to the inadequacy of treatment facilities for severely mentally ill inmates is evidence of inadequacies in suicide prevention and response. A review of suicides in California prisons during the period between 1999 and 2004 found that 60 percent of all suicides during that period were "either foreseeable or preventable, and some were both."[38] "Major contributing factors in foreseeable or preventable deaths included inadequate clinical assessments, inappropriate interventions, incomplete referrals, missed appointments and appointments that were not rescheduled, unsupported diagnoses, failure to review records, assignments to inappropriate levels of mental health care, failure to provide protective housing, and the provision of inadequate or untimely resuscitation efforts."[39] Those findings were consistent with the testimony of experts that inadequacies in treatment, including those that "appear to be the direct result of . . . severe overcrowding-related problems," had impacted suicide rates.[40]

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[37] *See* Stewart Report at 61.

[38] Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 Psychiatric Services 676, 679 (2008), Ex. D1281. "The term 'foreseeable' refers to cases in which already known and reasonably available information about an inmate indicates the presence of a substantial or high risk of suicide that requires responsive clinical, custody, or administrative interventions to prevent self-harm. The term foreseeable is not to imply 'predictable,' because suicide is not predictable . . . . The term 'preventable' applies to situations where if some additional information had been gathered or some additional interventions had been undertaken, usually as required in existing policies and procedures, the likelihood of completed suicide might have been substantially reduced." *Id.* at 679-80.

B. Research Shows that Overcrowding May Lead to Conditions that Exacerbate Existing Mental Illness

The three-judge district court's conclusion that prison crowding exacerbated inmates' mental illness is likewise consistent with the scientific literature on the psychological effects of prison crowding.

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[39] *Id.* at 680.

[40] Haney Report at 187; *see also, e.g.*, Stewart Report at 34 (describing inappropriate housing of suicidal inmates as a result of the inadequate number of appropriate MHCBs and outpatient housing). A recent report of the Special Master in the *Coleman* case reported that there were at least 36 suicides in California prisons in 2008, 25 in 2009, and 26 as of September 2010. *See* Special Master's Report on Defendant's Review of Suicide Prevention Policies, Practices, and Procedures at 7, 32, *Coleman v. Schwarzenegger*, No. CIV S-90-0520 LKK JFM P (E.D. Cal. filed Sept. 27, 2010) (Docket Entry 3918). The State acknowledges that the rate of suicide in administrative segregation "remained a concern." *Id.* at 7-8. In April, the district court in the *Coleman* case found that "[t]he increase in both the inmate suicide rate and the percentage of suicide cases with 'at least some degree of inadequacy in assessment, treatment, or intervention' is deeply troubling." Order at 6, *Coleman v. Schwarzenegger*, No. 2:90-cv-0520-LKK-JFM (PC) (Apr. 14, 2010) (Docket Entry 3836).

There is evidence in the behavioral science literature that crowding is directly correlated with negative impacts on inmates' physical and mental health. Behavioral science researchers have reported that "[i]ncreases in population in prisons where facilities are not increased proportionately are associated with increased rates of death, suicide, disciplinary infraction, and psychiatric commitment."[41] A review article from 1990 found that "physiological and psychological stress responses . . . were very likely under crowded prison conditions."[42] Studies also have associated crowding with higher rates of violence and increased disciplinary infractions.[43]

In addition, there was evidence before the three-judge district court that overcrowding contributed to conditions of confinement that may contribute to or aggravate mental illness. *See* JS1-App. 100a-104a. There was testimony that overcrowding led to use of "bad beds," for example, rows of triple bunks in converted gyms.[44] Dr. Stewart gave his opinion that, "[f]or [CCCMS] inmates who are routinely triple-bunked in chaotic, overcrowded dorms, this means they may experience damaging levels of stress and fear of predation, as well as sleep deprivation. These conditions exacerbate mental illness and are serious barriers to the provision of minimally adequate mental health and medical care."[45]

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[41] Verne C. Cox et al., *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach Regarding Crowding Phenomena*, 39 Am. Psychol. 1148, 1156 (1984).

[42] James Bonta & Paul Gendreau, *Reexamining the Cruel and Unusual Punishment of Prison Life*, 14 L & Human Behav. 347, 351 (1990).

[43] *See* Gerald Gaes & William J. McGuire, *Prison Violence: The Contribution of Crowding Versus Other Determinants of Prison Assault Rates*, 22 J. Res. in Crime & Delinq. 41 (1985); Peter L. Nacci et al., *Population Density and Inmate Misconduct Rates in the Federal Prison System*, 41 Fed. Probation 26, 29 (1977).

[44] Stewart Supplemental Report at 27-28.

The psychiatric literature supports Dr. Stewart's opinion regarding the impact of stressful and chaotic conditions of confinement. "Psychological stress has an important role in both the onset and course of mental illness, including schizophrenia, anxiety disorders, and depression."[46] A review of studies on sleep disturbance in patients with bipolar disorder noted a consistent relationship between insomnia and exacerbation of mood symptoms.[47] Insomnia also has been associated with anxiety and other psychological disorders,[48] including consistent association with depression.[49]

Further, there was evidence before the three-judge district court that, as a result of overcrowding, prisoners were subject to frequent lockdowns and enforced idleness because fewer facilities were available for correctional services, activities, and programming.[50] Research has shown that inmates are more depressed, anxious, and stressed when they are less involved in structured activities;[51] the lack of purposeful activity was identified in one British study on inmate suicide as the factor most strongly correlated with rates of suicide.[52] In overcrowded prisons, inmates lose opportunities for activities that can aid in adjustment to prison life. The evidence that such conditions lead to bad mental health outcomes – further aggravating the burdens on the mental health care resources in the prisons – supports the three-judge district court's findings.

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[45] *Id.* at 28-29; *see also id.* at 22-23 (explaining opinion that housing in multi-occupancy dorms "may exacerbate mental health conditions such as paranoia and create stressful environments for people who are otherwise vulnerable due to mental health issues, including cognitive impairments").

[46] John Herbert, *Fortnightly Review: Stress, the Brain, and Mental Illness*, 315 British Med. J. 530, 531 (1997); *see also* Cheryl Corcoran et al., *The Stress Cascade and Schizophrenia: Etiology and Onset*, 29 Schizophrenia Bull. 671 (2003).

[47] *See* Allison G. Harvey, *Sleep and Circadian Rhythms in Bipolar Disorder: Seeking Synchrony, Harmony, and Regulation*, 165 Am. J. Psychiatry 820, 822 (2008).

[48] *See* Daniel J. Taylor et al., *Insomnia as a Health Risk Factor*, 1 Behav. Sleep Med. 227 (2003).

[49] *See* Thomas Roth & Timothy Roehrs, *Insomnia: Epidemiology, Characteristics, and Consequences*, 5 Chronic Insomnia 5 (2003).

* * * * *

The members of the *Coleman* class have been denied constitutionally adequate mental health care – despite persistent remedial efforts – for two decades.[53] All parties agreed below that overcrowding is a significant factor in creating the unconstitutional conditions of confinement that confront more than 34,000 mentally ill inmates in California's prisons, inflicting needless suffering on many of them. The three-judge district court's determinations that overcrowding is the primary factor and that no other relief would suffice are at bottom factual determinations – reviewed with appropriate deference on appeal. Those determinations can best be evaluated in light of the understanding of experts in correctional mental health that adequate mental health care demands adequate physical and human resources as well as adequate access for inmates to those resources in a reasonable period of time.[54] The evidence that overcrowding renders resources and access inadequate thus supports the ruling below.

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[50] *See* Haney Report at 35.

[51] *See* John D. Wooldredge, *Inmate Experiences and Psychological Well-Being*, 26 Crim. Just. & Behav. 235, 243-44, 246-47 (1999).

[52] Morven Leese et al., *An Ecological Study of Factors Associated with Rates of Self-Inflicted Death in Prisons in England and Wales*, 29 Int'l J.L. & Psychiatry 355 (2005).

[53] How the State may best comply with the district court's order is not before this Court. Many law enforcement, correctional, judicial, and mental health experts agree that diversion of individuals with mental illness from the criminal justice system in appropriate circumstances can address crowding in a manner that is cost-effective and does not compromise public safety. *See, e.g.*, Council of State Governments, Criminal Justice / Mental Health Consensus Project (June 2002), *available at* http://consensusproject.org/downloads/Entire_report.pdf, *Criminal Justice Responses to Offenders with Mental Illness*

CONCLUSION

The judgment of the three-judge district court should be affirmed.

Hearing Before the Subcomm. on Crime, Terrorism, and Homeland Security of the H. Comm. on the Judiciary, 110th Cong. (2007) (emphasizing the importance of pre- and post-detention diversion programs for individuals with mental illness); APA *Psychiatric Services* at 29-30.

[54] *See* Metzner, *Correctional Psychiatry: Part I, supra*.

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AMICUS CURIAE BRIEF

Supreme Court, U.S.
[illegible]

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
Appellants,

v.

MARCIANO PLATA and RALPH COLEMAN, *et al.*,
Appellees.

On Appeal from the United States District Courts for the Eastern District and Northern District of California

BRIEF OF *AMICI CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN NURSES ASSOCIATION, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ACADEMY OF CORRECTIONAL HEALTH PROFESSIONALS, AND SOCIETY OF CORRECTIONAL PHYSICIANS IN SUPPORT OF APPELLEES

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INTEREST OF *AMICI CURIAE*[1]

Amici represent a broad array of health care professionals and researchers dedicated to improving public health. Many of *amici's* members work in California's correctional facilities and therefore share a direct stake in the outcome of this litigation and its implications for the medical well-being and physical safety of correctional staff, prisoner-patients, and the public at large.

Founded in 1872, the American Public Health Association (APHA) is the oldest and most diverse organization of public health professionals in the world, with over 50,000 individual and affiliate members. APHA aims to protect all Americans and their communities from preventable, serious health threats. It seeks to ensure that community-based health promotion, disease prevention activities, and preventive health services are universally accessible in the United States. Through its two flagship publications, the peer-reviewed *American Journal of Public Health* and the award-winning newspaper *The Nation's Health*, APHA promotes the latest public health science.

The American Nurses Association (ANA) is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses. Founded in 1896, ANA develops the Code of

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[1] Pursuant to S. Ct. R. 37.6, counsel for *amici curiae* affirm that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *amici curiae*, their members, or their counsel made a monetary contribution to this brief's preparation or submission. The parties have consented to the filing of this brief in letters submitted to the Court.

Ethics for Nurses and the standards of nursing practice, and it actively promotes patient safety, workplace rights, appropriate staffing, workplace and environmental health and safety, and the public health. With members in every state, ANA advances the nursing profession and public health through its constituent member associations. ANA and its affiliates collectively represent nearly 500,000 registered nurses.

The American Association of Public Health Physicians (AAPHP) was founded in 1954 to serve as the national voice of physician directors of state and local health departments. AAPHP represents physicians in all aspects of population medicine and advocates on their behalf to improve the public's health. AAPHP is noted for its expertise in broad areas of population and public health medicine, including correctional health care, disease control, policy and management training, and issues pertinent to health care access. As a recognized specialty, AAPHP represents physicians and their public health agenda in the American Medical Association House of Delegates.

The Academy of Correctional Health Professionals (ACHP) is a national organization founded in 2000 to provide educational and professional development tools to correctional health care professionals. ACHP works to promote education and information exchange within the correctional health care community, advance the science and ethical practice of correctional health care, and advocate for correctional health care excellence.

Formed in 1992, the Society of Correctional Physicians (SCP) is the nation's largest membership organization of doctors specializing in correctional health care. As the foremost physicians' professional society in this field, SCP works with other correctional and non-correctional leaders in science, education, and policy to review, promote, and establish the highest ethical ideals and service standards in correctional medicine; to promote evidence-based clinical practice through continuing physician education; to encourage research in correctional health care issues; and to enhance the value of health care delivered to our incarcerated population.

For decades *amici* have developed, implemented, and promoted specific standards on the proper administration of prison health care to help correctional staff, governments, and courts understand the clinical needs of the prison setting. These standards are reflected in several published texts, including:

- The American Correctional Association's *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (2002 & Supp. 2010) ("ACA Standards");
- The National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2008) ("NCCHC Standards");
- ANA's *Corrections Nursing: Scope and Standards of Practice* (2007); and
- APHA's *Standards for Health Services in Correctional Institutions* (3d ed. 2003) ("APHA Standards").

Originally published in 1976, the APHA Standards was the first set of professional health care guidelines for prisons and jails. Over the years, leaders in the field of correctional care—including penal medical directors, legal experts, educators, researchers, advocates, and correctional consultants—have periodically updated these standards to reflect current health care practices.

Amici believe that an understanding of these standards in the context of California's prison system will assist the Court's resolution of this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

In California's prisons, bathrooms and closets are being used for clinical examinations, JS1-App. 19a (findings of the three-judge court below); understaffed health care workers fear for their personal safety, *id.* at 107a; and inmates continue to die while they wait months or years to receive urgent medical care and medications. *Id.* at 112a, 115a. "As of mid-2005, a California inmate was dying needlessly *every six or seven days*" because the State failed to provide minimally adequate health care in its correctional facilities. *Id.* at 9a. By 2009, the death rate had barely improved, with one prisoner dying unnecessarily every eight days. *See infra* p. 23. Appellees filed this lawsuit to remedy these constitutional crises, among others.

California does not dispute the woeful health care conditions in its prisons or that its prison system is dangerously overcrowded. Indeed, Governor Schwarzenegger recognized the crisis caused by these deplorable conditions and declared a State of Emergency due to prison overcrowding on October 4, 2006. Four years later, that State of Emergency remains in effect.

Nevertheless, California accuses the court below of "[u]sing the guise of providing healthcare that complies with the Eighth Amendment . . . to undertake comprehensive institutional reform directed at prison crowding." Appellants' Br. 10. But prison overcrowding and systemic health care failures go hand-in-hand.

The Court need look no further than the factual findings below to determine that this case *is* about health care, and by any measure, the health care conditions in California's prisons are deplorable. They fail to meet even the bare minimum standards developed by *amici* to guarantee the possibility of adequate health care in prisons. Alleviation of overcrowding—the remedy ordered by the three-judge court—is necessary to improve health care in California's prisons because systemic structural limitations cannot otherwise be resolved.

The public health consequences are alarming if these problems remain unaddressed. In 2009 alone, California's prisons experienced over 300 extreme lapses in clinical care, resulting in 46 likely- or possibly-preventable deaths. Kent Imai, MD, *Analysis of Year 2009 Death Reviews* (Sept. 2010), p. 9 ("Year 2009 Death Reviews"), *available at* http://www.cphcs.ca.gov/docs/resources/OTRES_DeathReviewAnalysisYear2009_20100907.pdf (last accessed Oct. 29, 2010). And the conditions have consequences beyond prison walls. Infectious diseases are rampant within prisons. As they spread due to cramped living quarters and risky behavior among inmates, communicable diseases present health risks to prison workers, visitors, and the community at large.

Amici offer this brief to explain the severity and immediacy of the public health crisis caused by prison overcrowding and to elaborate on the appropriate health care standards for correctional facilities. The published standards of *amici* are nationally-recognized as required care, and many of the benchmarks set forth in this brief have been adopted in consent decrees and endorsed by courts.[2] This Court previously has found such model rules helpful in understanding the proper administration of prison care. *See Estelle v. Gamble*, 429 U.S. 97, 103-104 n.8 (1976) (citing various prison standards).

Amici recognize the political challenges here. Prisoner rights are often low on governmental priority lists, perhaps even more so during challenging fiscal periods. But we are not suggesting the need for state-of-the-art care or even average facilities, staffing, and access to care. California lacks the *bare minimum* needed to treat those patients who suffer from serious medical conditions. Tellingly, although California's *amici* questioned the utility of professional standards, Br. of *Amici* Louisiana et al. 18-21, they did not propose alternative benchmarks or even attempt to defend the conditions in California's prisons.

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[2] *See, e.g.*, *Harris v. City of Philadelphia*, 35 F.3d 840, 843 (3d Cir. 1994) (APHA and ACA standards incorporated into consent decree); *Williams v. Cearlock*, 993 F. Supp. 1192, 1196 (C.D. Ill. 1998) (prison system accredited by ACA found to be constitutionally adequate); *Tumath v. County of Alameda*, No. C 95-3289, 1996 WL 660611, at *3 (N.D. Cal. Nov. 6, 1996) (prison system accredited by NCCHC found to be constitutionally adequate); *Palmigiano v. DiPrete*, 737 F. Supp. 1257, 1261 (D.R.I. 1990) (accepting expert testimony based on APHA medical standards); *Cody v. Hillard*, 599 F. Supp. 1025, 1028 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986), *on reh'g*, 830 F.2d 912 (8th Cir. 1987) (evaluating prison conditions "based in part on the degree of compliance with the 'most important' correctional standards promulgated by two nationally-recognized associations of experts in the field of corrections: the American Correctional Association (ACA) and the American Public Health Association (APHA)"); *Nobles v. Duncil*, 505 S.E.2d 442, 451 (W. Va. 1998) (prison system accredited by NCCHC found to be constitutionally adequate).

Our standards constitute the *minimum* conditions necessary to provide required health care in prisons. They do not reflect, for example, best practices at community hospitals. As professionals who have dedicated our careers to the study of correctional health care and public health, we appreciate the challenges and unique features of prisons. That understanding is reflected in our recommendations and conclusions here.

ARGUMENT

Following a month-long trial, the three-judge court below found that California has failed to provide minimally adequate health care due to the deplorable conditions in California's correctional facilities. Based on the findings of fact in this lawsuit, we agree. California prisons do not meet our nationally-recognized standards for required medical care. *Amici* designed these standards not only to protect prisoner-patients, but also to ensure the health and safety of health care practitioners, correctional staff, and the community at large. California's failure to comply with these minimally adequate standards creates public health problems that reach beyond the prison walls.

I. HEALTH CARE IN CALIFORNIA'S PRISONS FALLS WOEFULLY SHORT OF MINIMALLY ADEQUATE STANDARDS

Inmates have no choice in their health care provider. "[H]aving stripped them of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course." *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). Our Constitution does not tolerate a government official's deliberate indifference to the serious medical needs of prisoners. As the Court recognized in *Estelle v. Gamble*, "[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." 429 U.S. at 103.

Prison overcrowding can jeopardize, and often prevents, the delivery of adequate health care to prisoner-patients. Although overcrowding can adversely impact all aspects of health care in prisons, it directly inhibits the system's ability to provide sufficient facilities, staffing, and access to care.

A. California's Prison Facilities Impede the Delivery of Proper Care in Violation of National Standards

In California's prisons, "available clinical space is less than half of what is necessary for daily operations." JS1-App. 93a. At Avenal State Prison, for instance, "staff must attempt to provide care for 7,525 inmates in space designed for less than one-third of that number." *Id.* The lack of adequate office and treatment space is "endemic in the CDCR [California Department of Corrections and Rehabilitation]." *Id.* Corrections experts uncovered a shortage of clinical space at nearly every facility, including California Institution for Men, Valley State Prison for Women, San Quentin, North Kern State Prison, Pleasant Valley State Prison, California State Prison-Solano, the Substance Abuse and Treatment Facility at Corcoran, the Correctional Training Facility, and California State Prison-Los Angeles County. *Id.* at 93a-95a. The space shortage is a direct result of the overcrowded population. As the Receiver appointed to oversee prison operations in California concluded, "[t]here is a dire need for additional clinical space . . . in the prisons because the existing capacity has been swamped by the number of inmates in the system." *Id.* at 95a.

Similarly, none of the CDCR's designated reception centers were "designed or constructed with adequate clinical space." JS1-App. 87a. "To make matters worse, as the original prisons designated for reception became overwhelmed by the influx of parole violators, the CDCR was forced to 'convert' general population prisons into reception centers. These 'conversions,' however, were not accompanied by adequate additions to clinical staff or clinical space." *Id.* As a result, rooms are "so small that it would be difficult if not impossible to perform an actual physical examination in them." *Id.* at 88a.

Even where available clinical space—albeit limited—exists, the conditions of those facilities are deplorable. In San Quentin, a nursing expert described the treatment setting:

> [T]he area used for nursing triage [was] a small room at the end of the tier that the nurse accesses by walking through a gate and into the men's showers. . . . Because of a clogged shower drain, standing water was present outside the clinic door. Inside, the room was filthy. The furniture was old and in disrepair. There was no examination table, medical equipment or supplies, or handwashing facilities. According to staff, equipment (otoscope [an instrument used to examine the ear]) requested for this area had been denied. As well, there was no telephone or computer access. Prior to this room being used, a broom closet on the fourth tier was used for nurse triage.

JS1-App. 19a. In short, the nursing expert concluded, the "conditions are deplorable and have no resemblance to a medical setting whatsoever." *Id.* at 20a.

San Quentin is not an isolated example. "Many clinics [did] not meet basic sanitation standards. Exam tables and counter tops, where prisoners with infections such as Methicillin-Resistant Staph Aureus (MRSA) and other communicable diseases are treated, [were] not routinely disinfected or sanitized." JS1-App. 27a. And other "facilities require[d] fundamental repairs, installation of adequate lighting and such basic sanitary facilities as sinks for hand-washing." *Id.* Indeed, "lack of adequate hygiene ha[d] forced the closure of some operating rooms." *Id.* At the time of trial in late 2008, these dreadful conditions remained the status quo. *See id.* at 85a-95a.

These findings demonstrate that California's prison facilities are wholly unsuitable to meet the health needs of inmates. "We are dealing not with deferred maintenance, but with some facilities that are literally falling apart." JS1-App. 93a. It is unrealistic to expect clinical physicians and nurses—whom *amici* represent and support—to perform their jobs adequately in such conditions, which fall far short of *amici*'s standards for prison facilities. To provide basic care, clinics, infirmaries, and other medical care facilities must include at the very least: examination, treatment, and isolation rooms; toilets and sinks; nursing stations; adequate lighting; central and general storage; and medical records storage. APHA Standard II.E.1; *see also* NCCHC Standard P-D-03. Health care staff must have office space to maintain files and have access to telephones, facsimile machines, copiers, and properly-equipped computers with appropriate software. APHA Standard II.E.1.

And while it should go without saying, medical areas must meet basic sanitary requirements, must be adequately disinfected and sterilized, and must include necessary equipment to treat and care for patients. *Id.* California's prison facilities, as noted, fail to meet these basic requirements.

Moreover, California does not have sufficient clinical space to ensure, much less foster, confidential patient communication. "Exams are conducted in areas separated only by a thin white fabric folding screen that is approximately five to six feet tall[,] and conversations between physicians and inmates can be overheard on the other side of the screen." JS1-App. 88a. At North Kern State Prison, inmate health interviews "are conducted in a small office, with prisoners sitting back to back, separated only by a shoulder-high divider." *Id.* As a result, "fundamental medical confidentiality rights are routinely ignored." *Id.* at 94a.

This is unacceptable. Health care services must be provided in private settings to ensure patient-provider confidentiality and encourage the patient's subsequent use of medical care. *See* American Medical Association, Code of Medical Ethics Opinion 5.05—Confidentiality (2007), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/ code-medical-ethics/opinion505.shtml (last accessed Oct. 29, 2010). This core requirement applies in the prison setting as well. APHA Standards II.E & III.B.4; NCCHC Standard P-A-09; ACA Standard 1-HC-3A-10. Indeed, the need for a private setting is heightened in prison where the patient lives in crowded quarters with other prisoners who could use and abuse medical information about the prisoner. Prisoners forced to convey their health information in front of other prisoners, therefore, are particularly unlikely to communicate frankly about the nature or extent of their medical needs, thereby thwarting the clinician's ability to diagnose and provide appropriate care.

B. California's Prison Clinical Staffing Prevents Even Basic Medical Care in Violation of National Standards

California's clinical staffing record is similarly poor and a direct consequence of overcrowding. The three-judge court found a chronic shortage of medical personnel. Existing employees were insufficiently credentialed and not equipped to handle their basic responsibilities.

"Defendants' own data demonstrates significant vacancy rates for medical staff. As of August 2008, 20 percent of chief physician and surgeon positions, 25 percent of physician positions, 19 percent of physician assistant positions, 39 percent of nurse practitioner positions, 10 percent of registered nurse positions, and 18 percent of licensed vocational nurse positions remained vacant." JS1-App. 105a. These staffing shortages led to predictable "significant appointment delays," *id*. at 106a, and an inability "to develop required medical programs, including the chronic and preventive care programs." *Id*. Even if California could mount a successful recruitment campaign, prisons "would not have sufficient space for clinical staff if all of the clinical positions currently budgeted were filled, let alone if new positions were created and filled." *Id*. at 107a.

The court also found that prison health care workers were ill-equipped to perform their duties. "According to one court expert, 20-50% of physicians at the prisons provide[d] poor quality of care." JS1-App. 28a.

"CDCR nurses often fail[ed] to perform basic functions, such as taking vital signs, conducting examinations, and identifying urgent medical issues requiring immediate referral to a physician." *Id.* at 26a. Prison administrators share the fault for these lapses because "the CDCR's lack of a medical credentialing policy resulted in many CDCR clinicians' practicing outside of their areas of medical expertise." *Id.* at 28a.

These staffing deficiencies stem from California's prison overcrowding. The court concluded: "[c]rowding [] makes it impossible for the CDCR to hire the additional staff necessary to provide constitutionally adequate medical and mental health care to the current population." JS1-App. 105a. "[M]any newly hired clinicians will be unwilling to risk their professional credentials and reputations by practicing in an environment where their patients are at risk of harm because among other things adequate clinical space is scarce, appointments are not scheduled, complete medical records are unavailable, and medications are not delivered." *Id.* at 107a.

Again, these prison staffing practices are an affront to *amici*'s minimum standards. The staffing level for prison health care programs must be of sufficient size and composition to provide prisoners with adequate health care. APHA Standard II.C.1; NCCHC Standard P-C-07; ACA Standard 1-HC-4A-05. This requires staff for direct treatment services as well as for consultation, training, administration, evaluation, and quality improvement. APHA Standard II.C.1. Budgetary resources to support recruitment and employment of health care staff must be on par with the cost of care for non-incarcerated populations, APHA Standard II.C.3, and staff must be appropriately trained and not be asked to perform health services beyond their training. APHA Standard II.C.10; NCCHC Standard P-C-01; ACA Standard 1-HC-2A-03.

Moreover, adequate staffing is not just about new hires; California must also retain the qualified clinicians already serving the prison population. Service coverage by physician's assistants, nurses, and administrative personnel must be relatively stable to assure that health services are adequately planned, delivered, and monitored. APHA Standard II.C.4. Yet, staff shortages and high turnover persist because "crowding interferes with the ability to recruit, hire and retain competent medical personnel." JS1-App. 107a.

C. California's Prisons Prevent Needed Access to Care in Violation of National Standards

Overcrowding also has a direct and negative impact on inmates' access to care. Adequate access to care is the rudimentary goal in any health care system. It encompasses a patient's timely access to basic medical services and medication, a provider's access to accurate medical records, and an adequate emergency response system. Incarcerated individuals have the same right as those in the community to access an appropriate level of care in a timely fashion. APHA Standard I.B; *see also Estelle*, 429 U.S. at 103 (recognizing "the government's obligation to provide medical care for those whom it is punishing by incarceration").

But in California's prison system, none of these basic requirements are met. "Inmates are forced to wait months or years for medically necessary appointments and examinations, and many receive inadequate medical care in substandard facilities that lack the medical equipment required to conduct routine examinations or afford essential medical treatment." JS1-App. 9a. In one instance, "inmates with consultation referrals from early 2004 had yet to be seen in May 2005." *Id.* at 25a. At Avenal State Prison, an expert observed "1,293 pending specialty referrals, 316 urgent and 977 routine. Of the 316 pending urgent referrals, only approximately 105 had an appointment date, with only 2 of the 316 urgent referrals—a dismal 0.6 percent—scheduled to take place within the fourteen-day period . . . ." *Id.* at 115a.

Similarly, inmates must endure extreme lapses in the supply of medication because "the management of prison pharmacy operations was 'unbelievably poor.'" JS1-App. 27a. This, too, is caused by overcrowding. As the three-judge court found, "crowding prevents defendants from achieving an adequate medication delivery system that is marked by the timely delivery of the correct medication to the correct patient . . . ." *Id.* at 112a. "Defendants' medication delivery systems are inadequate for the size of the population they serve, and are plagued by short-staffing at a number of prisons . . . . [Consequently,] prisoners receive their medications late or not at all, and suffer as a result." *Id.*

These shocking delays and lapses in medical access flaunt national standards and deny any meaningful medical care. Prison officials must provide prompt hospitalization and specialty care (e.g., surgery and orthopedics) to patients in need of those services, and inmates are entitled to receive the treatment and diagnostic tests ordered by clinicians. APHA Standards III.D & F; NCCHC Standards P-D-04, D-05, & E-12; ACA Standards 1-HC-1A-05, 09, & 16. Prisons should have prescription-based medication delivery systems that guarantee prisoners will receive, without interruption, chronic medication in a timely and continuous manner, as directed by the prescribing physician or provider. APHA Standards, Chapter 4: Chronic Care Management; NCCHC Standard P-D-02. To that end, every prison must have a secure pharmacy appropriate to the size of the prisoner population served. APHA Standard VI.G; NCCHC Standard P-D-01; ACA Standard 1-HC-1A-35.

California's inability to process and store medical records exacerbates its poor delivery of care. "CDCR cannot track and transfer essential health care records, because the record system lacks the capacity to deliver records regarding this many prisoners." JS1-App. 118a. Medical records were "dangerously incomplete" in the opinion of one expert. *Id.* at 119a. "Medical records in most CDCR prisons were either in shambles or non-existent . . . mak[ing] even mediocre care impossible." *Id.* at 27a. As a result, CDCR has "failed to develop or implement a system to track and treat inmates with chronic care needs," *id.* at 25a-26a, even though an accurate and complete health record is an essential instrument for delivery of health services and must be available for every prisoner. APHA Standard II.F; NCCHC Standard P-H-01 & H-04; ACA Standard 1-HS-4A-06; *see also* American Medical Association, Code of Medical Ethics Opinion 7.05—Retention of Medical Records (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion705.shtml (last accessed Oct. 29, 2010).

Overcrowding also prevents correctional staff from adequately responding to medical emergencies. Emergency care and access to urgent medical treatment must be available at all times, 24 hours per day. APHA Standard III.E; NCCHC Standard P-E-08; ACA Standard 1-HC-1A-08. Emergency requests should be reviewed immediately, and correctional staff with emergency skills must be able to enter any living area within 60 seconds to evacuate or treat prisoners in emergency situations. APHA Standard I.B.3 & B.10; *see also* ACA Standard 1-HC-2A-14 (four-minute emergency response). Patients requesting non-emergency medical assessments should be triaged or seen by independent licensed practitioners within 24 hours of their requests. APHA Standard I.B.3; NCCHC Standard P-E-07.

California's prisons do not have the capacity to achieve these standards. Overcrowding and understaffing seriously inhibit the ability of prison staff to identify and respond to medical emergencies:

> In a housing unit such as San Quentin's H Unit Dorm 2 (one officer for 200 prisoners) or CIM's West Facility Cleveland Hall (two officers for 198 prisoners) or East Facility Gym (two officers for 202 prisoners), staff in an emergency can only sound the alarm, make frantic telephone or radio calls, and hope for backup. An officer alone with several hundred inmates is unlikely, for example, to perform emergency first aid or CPR—it is simply unsafe to do so with no backup, when prisoners could easily simulate an emergency as a diversion. The inability to perform basic lifesaving functions could have potentially devastating consequences on the life and health of a prisoner undergoing a medical or mental health emergency. This situation presents an unacceptable risk of harm to prisoners.

JS1-App. 111a.

At trial, a former California prison official described the assault of one prisoner in a crowded gymnasium that had been converted to overflow housing. Because of overcrowding and understaffing, prison officials did not learn of the assault—much less provide emergency aid—until after the victim had died. *See* Trial Tr. 382:2-383:3.

It is readily apparent why California does not attempt here to defend the conditions of its prisons. Clinical facilities are few and filthy, staffing is low and strained, and access to care is delayed or nonexistent. California's prison system fails almost every benchmark established by *amici* to guarantee the possibility of minimally adequate health care.

II. CALIFORNIA'S SUBSTANDARD DELIVERY OF HEALTH CARE IN PRISONS THREATENS PUBLIC HEALTH AND RESULTS IN UNNECESSARY, PREVENTABLE DEATHS.

California's inability to provide adequate medical care results in preventable deaths and an increased spread of infectious diseases both within and beyond correctional facilities.

1. Cramped living conditions and risky behavior lead to exceptionally high rates of infectious diseases in prisons. Inmates have a disproportionately greater prevalence of tuberculosis (TB), hepatitis C virus (HCV), and HIV/AIDS, among other diseases. Cindy Weinbaum et al., *Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings*, 52 Morbidity and Mortality Weekly Report 1, 1 (Jan. 24, 2003); *see also* Niyi Awofeso, *Prisons as Social Determinants of Hepatitis C Virus and Tuberculosis Infections*, 125 Pub. Health Reports 25, 31 (Supp. 4

2010) ("As social determinants, prisons exert a particularly strong influence on the epidemiology of HCV and TB infections."). Nationwide, tuberculosis case rates in correctional populations are ten times higher than the general population;[3] hepatitis C rates are 8-20 times higher;[4] and HIV rates are 5-10 times higher.[5]

In California's prisons, elevated infection rates are a direct result of overcrowding. According to Scott Kernan, then-Chief Deputy Secretary of the Division of Adult Institutions for California's prisons, overcrowding "has led to increased numbers of infectious disease outbreaks," including eleven different outbreaks (or possible outbreaks) of tuberculosis at seven California prisons. JS1-App. 102a. Other experts echoed concerns about increased outbreaks of infectious diseases, *id.*, and Dr. Ronald Shansky concluded, "[u]ntil CDCR reduces its population, it will remain highly vulnerable to outbreaks of communicable diseases, including staph infections, tuberculosis and influenza." *Id.*

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[3] Jessica R. MacNeil et al., *An Unanswered Health Disparity: Tuberculosis Among Correctional Inmates, 1993 Through 2003*, 95 Am. J. of Pub. Health 1800, 1800 (2005).

[4] Amy E. Boutwell et al., *Opportunities to Address the Hepatitis C Epidemic in the Correctional Setting*, 40 Clinical Infectious Diseases S367, S367 (Supp. 5 2005) ("[R]ecent estimates of the magnitude of the HCV epidemic in prisons are staggering. . . . These rates indicate that the prevalence of HCV among prisoners is 8-20 times higher than that of the general US population."); Zulficar G. Restum, *Public Health Implications of Substandard Correctional Health Care*, 95 Am. J. of Pub. Health 1689, 1689 (2005) (hepatitis C infects more than 41% of California inmates, compared with less than 2% of the state's general population).

[5] Lois M. Davis et al., RAND Corporation, *Prisoner Reentry: What Are the Public Health Challenges?* (2003), p. 2 (HIV rates 8-9 times higher; AIDS rates 5 times higher), *available at* http://www.rand.org/pubs/research_briefs/RB6013/ (last accessed Oct. 29, 2010); Restum, *supra* note 4, at 1689 (estimating a prison HIV "rate 10 times higher than among nonprisoners").

High infection rates intensify the need for adequate screening and medical care. As previously noted, California's screening and treatment fall woefully short of nationally-recognized standards. Exacerbating the situation, California's prisons lack protocols to treat hepatitis and HIV, among other chronic illnesses. JS1-App. 15a. Thus, overcrowded conditions in California foster a dangerous escalation of disease transmission: inmates enter prison with high infection rates, overcrowding increases the spread of infectious diseases, and clinicians cannot mitigate transmission risks without adequate prisoner screening and treatment options. As explained above, correctional health care workers lack the resources needed to adequately screen or treat prisoners because of overcrowding.

2. The epidemiological consequences of California's substandard delivery of correctional health care reach beyond the prison walls. Correctional facilities are open, not closed, societies—as visitors, guards, administrators, and clinical staff enter prisons and jails every day and return home to their communities each night. Additionally, 171,556 California prison inmates reentered the general population in 2008. CDCR, *Corrections Moving Forward* (2009), p. 8. The turnover rate in jails is considerably higher; local jails experienced a *weekly* turnover rate of 63.7% nationally in 2009. Bureau of Justice Statistics, *Jail Inmates at Midyear 2009—Statistical Tables* (June 2010), p. 7, *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/jim09st.pdf (last accessed Oct. 29, 2010). Collectively, about 10 million people are released

from incarceration each year in the United States. Timothy P. Flanigan et al., *HIV and Infectious Disease Care in Jails and Prisons*, 120 Transactions Am. Clinical & Climatological Assoc. 73, 74 (2009).

This revolving door of correctional staff, visitors, and prisoner-patients makes it imperative to include incarcerated populations in community-based disease prevention and control strategies. Otherwise, their reentry into society will exacerbate the community's health care issues. Prison intervention and treatment is also fiscally prudent. "Improved access to medical care and prevention services for incarcerated populations can benefit communities by reducing disease transmission and medical costs." Weinbaum, *supra*, at 1. For example, "[l]eft unchecked, chronic liver disease stemming from hepatitis B and hepatitis C is projected to cost our nation's health care system more than $85 billion annually within 15 years and ravage minority populations, including millions within the African-American, Latino and Asian-American communities." Lorren Sandt, Roll Call, *Bipartisan Support Grows for Addressing Nation's Hepatitis Scourge* (Nov. 6, 2009), *available at* http://www.rollcall.com/news/40349-1.html (last accessed Oct. 29, 2010).

Incarceration represents a valuable opportunity to improve public health by treating underserved—and generally inaccessible—individuals. Community public health institutions struggle to provide services to the type of individuals in the prison population. In contrast, correctional health care professionals have direct access to this at-risk group and can address serious public health issues during incarceration, so long as those professionals are equipped with adequate resources.

California's inability to identify, treat, or mitigate the spread of infectious diseases is a missed opportunity for intervention. *See* Cindy M. Weinbaum et al., *Hepatitis B, Hepatitis C, and HIV in Correctional Populations: A Review of Epidemiology and Prevention*, 19 AIDS S41, S45 (Supp. 3 2005) ("Although correctional facilities are only required to provide adequate, reactive healthcare, entry into the correctional system provides an opportunity for a population at risk of HBV, HCV, and HIV infections to access preventative healthcare, including immunization, health education, substance abuse treatment, and risk reduction."); Awofeso, *supra*, at 30 ("In relation to HCV and TB infections, adequate interventions to limit transmission and to promptly treat infected inmates constitute a public health opportunity to reduce the burden of these diseases."); Centers for Disease Control and Prevention, *HIV Testing Implementation Guidance for Correctional Settings* (Jan. 2009), p. 5 ("The implementation of HIV testing in correctional settings is an important consideration in reducing the annual number of new HIV infections occurring in the United States."), *available at* http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/pdf/Correctional_Settings_Guidelines.pdf (last accessed Oct. 29, 2010). Because 1.3 million individuals who are infected with hepatitis C are released from prison annually, intervention and mitigation "efforts would affect not only the incarcerated population but also the community at large." Grace E. Macalino et al., *A Missed Opportunity: Hepatitis C Screening of Prisoners*, 95 Am. J. of Pub. Health 1739, 1740 (2005).

3. As a result of lapses in clinical care attributable to chronic overcrowding, incarceration too often becomes a death sentence for many California inmates.

"[I]t is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system." JS1-App. 25a (2005 findings). In 2007, "better medical management or a better system of care would likely have or may have prevented the patient's death" in 40 percent of natural, unexpected deaths. *Id.* at 124a-125a. In 2008, that statistic rose to 43 percent. Kent Imai, MD, *Analysis of Year 2008 Death Reviews* (Dec. 14, 2009), p. 9 ("Year 2008 Death Reviews"), *available at* http://www.cphcs.ca.gov/docs/resources/OTRES_DeathReviewAnalysisYear2008_20091214.pdf (last accessed Oct. 29, 2010).

California's prisons have seen little improvement, as catastrophic failures in the past continue today. In 2009, the Receiver observed 101 "severe lapses in care" in the 46 likely- and possibly-preventable deaths—more than two severe medical lapses per death. Year 2009 Death Reviews at 9. Even in deaths determined to be "non-preventable," the Receiver noted 205 severe lapses in medical care. *Id.* Overall, the most common lapse was a failure to recognize, identify, or adequately evaluate important medical symptoms or signs. *Id.* According to the Receiver, "It's not that we've got bad clinicians. It's that they're working in a third world environment." Julie Small, *Report Indicates Rise in Number of Preventable California Prison Deaths Since 2006* (Dec. 14, 2009), *available at* http://www.scpr.org/news/2009/12/14/report-fewer-inmates-dying-california-prisons/ (last accessed Oct. 29, 2010).

Currently, severe medical lapses continue to result in an unnecessary death every eight days in California's prisons. Year 2009 Death Review at 9. Thus, we reject as absurd the claim by California's *amici* that the "current conditions [of avoidable deaths] were dramatically better" at the time of trial. Br. for *Amici* Louisiana et al. 20. In reality, the death rate had *worsened* in 2008, with an inmate dying unnecessarily every 5.5 days. Year 2008 Death Reviews at 9 (66 likely- or possibly-preventable deaths in 2008). The three-judge court did not rely on outdated information when it considered these statistics and other historic evidence of prison conditions. Appellants' Br. 26-30. That historical evidence, combined with evidence of conditions in 2008, showed the systemic and ongoing nature of California's prison health care crisis.

* * *

"By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action." JS1-App. 24a. "[U]ntil the problem of overcrowding is overcome it will be impossible to provide constitutionally compliant care to California's prison population." *Id.* at 141a.

As clinicians and public health professionals, *amici* are committed to improving the health and well-being of our patients and the general public. We conclude, based on the factual record in this case, that the appalling conditions of facilities, staffing, and access to care in California's prisons prevent the delivery of minimally adequate health care, creating hazardous public health effects in prisons and surrounding communities. Given California's inability or unwillingness to remedy those violations during the past decade of this litigation, we endorse the conclusion of the three-judge court below that a reduction of the current level of overcrowding is a necessary precondition to achieving adequate health care in California's prisons.

Where the government can prevent the unnecessary suffering and death of individuals involuntarily committed to its care, it must do so. A mature and decent society tolerates nothing less. *See Estelle*, 429 U.S. at 102.

CONCLUSION

The "prison release order" issued by the three-judge court should be affirmed.

Respectfully submitted,

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ARNOLD SCHWARZENEGGER, GOVERNOR
OF THE STATE OF CALIFORNIA, ET AL.,
Appellants,

v.

MARCIANO PLATA, ET AL.,
Appellees.

**On Appeal from the
United States District Courts for the
Eastern and Northern Districts of California**

BRIEF OF CENTER ON THE ADMINISTRATION OF CRIMINAL LAW AND 30 CRIMINOLOGISTS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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November 1, 2010

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are the Center on the Administration of Criminal Law ("the Center") and 30 leading criminologists[2] who have substantial knowledge of and interest in criminal justice issues. *Amicus curiae* the Center is dedicated to defining and promoting best practices in the administration of criminal justice through academic research, litigation, and participation in the formulation of public policy. The Center's litigation component aims to use its empirical research and experience with criminal justice practices to assist in important criminal justice cases in state and federal courts throughout the United States. Criminologist *amici curiae* are leading criminologists and other prominent scholars and researchers in the criminology field whose work focuses on the interrelationship between crime and punishment, including the consequences of mass incarceration. The objective of *amici curiae* in this case is to provide this Court with an empirically and experientially grounded understanding of the public-safety implications of the three-judge district court's decision.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici* or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel for *amici* also represent that all parties have consented to the filing of this brief, and a letter reflecting their blanket consent to the filing of *amicus* briefs has been filed with the Clerk.

[2] A full list of *amici curiae* criminologists, who join this brief as individuals and not as representatives of any institutions with which they are affiliated, is set forth in the Appendix to this brief.

SUMMARY OF ARGUMENT

The three-judge district court correctly concluded that California could comply with the court's prison population reduction order without an adverse impact on public safety. The court began by noting that the current overcrowded state of California's prisons itself has a substantial negative impact on public safety. The court considered extensive evidence on methods by which California could reduce its prison population without an adverse impact on public safety, including measures that have been used successfully in other jurisdictions. Of particular interest are the expanded use of good-time credits and the diversion of low-risk prisoners with short sentences (less than six months) to community-based sanctions or drug treatment programs rather than incarceration in the state prison system. Under these programs, prisoners would be released just a few months sooner, on average, than otherwise. The district court painstakingly examined the evidence showing that applying these techniques would likely enhance, rather than impair, public safety.

Empirical evidence from other jurisdictions in which similar techniques have been used shows that they can be implemented without an increase in the crime rate. Many states, including New York, New Jersey, Illinois, Ohio, Michigan, and Massachusetts, as well as local jurisdictions in California, have carried out prison-release programs and experienced either no change or a decrease in crime rates. As these examples show, fewer prisoners does not equal more crime. The evidence also shows that incarceration's effectiveness at deterring crime depends on punishment being certain and swift, rather than on the length of incarceration. A growing body of evidence, including studies of early-release programs in Washington and Michigan, suggests that changing the length of incarceration is not associated with changes in either recidivism or crime rates. Hence, shorter prison terms does not equal more crime.

Just as *decreasing* the prison population does not predictably result in *more* crime, *increasing* the prison population does not predictably result in *less* crime. Extensive empirical evidence shows that states with higher incarceration rates tend to have higher (not lower) crime rates. Again, evidence from such places as New York, West Virginia, Alabama, Florida, and California's own counties, as well as national crime statistics, document the lack of a linear relationship between growth in prison populations and crime rates. Simply put, jurisdictions that incarcerate increasingly large percentages of their population are not consistently any more crime-free than other jurisdictions. Taken as a whole, the data suggest strongly that there comes a point after which the marginal benefit of increased incarceration diminishes and can lead to increased crime rates.

There are at least two ways in which high incarceration rates can lead to increased crime. First, prisons in general, and overcrowded prisons in particular, tend to be "criminogenic," that is, they tend to cultivate violence and criminality in offenders who otherwise might not have recidivated once released. Second, incarceration can lead to more crime in the communities from which the prisoners came. Even a short period of incarceration can lead to drastically reduced employment opportunities and hence to increased risk of criminal activity by ex-prisoners and those dependent upon them. In addition, parental incarceration disrupts child development and increases the odds that the children themselves will engage in criminal activity. By diverting selected low-risk prisoners to community-based sanctions and reducing prison terms by a few months on average, the California plan can contribute to reducing future criminal behavior by the prisoners themselves and by others in their communities. The parties and *amici* challenging the three-judge district court's order completely ignore the potential for this kind of positive impact on public safety.

The California plan for reducing prison population contains several elements that other jurisdictions have implemented (and, in some instances, that California itself previously had implemented) to reduce overcrowding without compromising public safety. The plan calls for the use of validated risk-assessment tools, which have been used with success in such places as Michigan, Mississippi, and Kansas. It calls for an expansion of the good-time credit system, which has worked well in, for example, New York, Illinois, Nevada, and Washington. And it calls for carefully targeted diversion of low-risk prisoners serving only a few months in prison to community-based sanctions. Similar programs have succeeded in New York, Kansas, Michigan, and Texas.

The available empirical evidence, as reflected in the experience of many states, thus strongly supports the three-judge district court's conclusion that its prison population reduction order can be implemented without compromising public safety.

ARGUMENT

I. THE THREE-JUDGE DISTRICT COURT PROPERLY FOUND THAT CALIFORNIA CAN SAFELY IMPLEMENT THE ORDERED REDUCTION IN PRISON POPULATION.

The three-judge district court ordered California to reduce its prison population to 137.5% of design capacity by the end of 2011. *See* JS1-App.[3] 169a. Furthermore, it determined that California could do so "without a meaningful adverse impact on public safety or the operation of the criminal justice system." *Id.* at 248a. Consistent with the mandate of the Prison Litigation Reform Act of 1995 ("PLRA"), 18 U.S.C. § 3626(a)(1)(A), the court thoroughly considered the potential for adverse effects on public safety. The court devoted nearly ten days of trial and more than 50 pages of its opinion to the public-safety issue. After carefully weighing an extensive body of evidence that included, among other things, testimony from "former and current heads of corrections of five states, top academic researchers in the field of incarceration and crime; CDCR officials; and county officials, district attorneys, probations officers and sheriffs from across California," JS1-App. 185a, the court concluded that California could comply with its prison population reduction order without an adverse impact on public safety.

The district court began by noting the strong evidence in the record that the current combination of overcrowding and inadequate rehabilitation programming in California's prison system itself has a

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[3] References to "JS1-App." are to the appendix accompanying the jurisdictional statement in No. 09-416; references to "09-1233 JS App." are to the appendix accompanying the jurisdictional statement in this case, No. 09-1233.

"substantial adverse impact on public safety." *Id.* at 188a. Petitioners/defendants did not "dispute the overwhelming evidence that overcrowding in prisons itself threatens public safety, nor could they." *Id.* at 191a. Even California's Governor Schwarzenegger recognized that "overcrowding causes harm to people and property, leads to inmate unrest and misconduct, reduces or eliminates programs, and increases recidivism as shown within this state and in others." *Id.* at 191a-192a (internal quotation marks omitted).

The district court also noted the "overwhelming agreement among experts for plaintiffs, defendants, and defendant-intervenors that it is 'absolutely' possible to reduce the prison population in California safely and effectively." *Id.* at 192a-193a. The court considered and described a wide variety of methods that California could use to achieve that goal, ranging from sentencing reform and modification of criminal statutes, to transfers of inmates to federal custody, to evidence-based rehabilitative programming. *Amici curiae* wish to highlight as especially promising two of the methods identified by the court: (1) expansion of good-time credits, and (2) diversion of low-risk offenders and technical parole violators.

California's good-time credit program allows inmates to "earn credits off their prison sentences through 'participation in work, educational, vocational, therapeutic or other prison activities' and for good behavior." *Id.* at 196a (quoting Cal. Penal Code §§ 2931, 2933). All of the experts who testified before the district court supported the expansion of this good-time credit system. *Id.* at 196a-197a. The evidence before the court indicated that such an expansion "would reduce the prison population by allowing inmates to shorten their lengths of stay in prison by a few months" and that "such moderate reductions in prison sentences do not adversely affect either recidivism rates or the deterrence value of imprisonment." *Id.* at 197a-198a. The court noted that California implemented early-release programs in 21 counties between 1996 and 2006, with approximately 1.7 million inmates released by court order without resulting in a higher crime rate. *Id.* at 202a-203a. Based on extensive record evidence, the court found that shortening an inmate's length of stay through earned credits would give inmates incentives to participate in programming designed to lower recidivism and that, overall, expanding the use of good-time credits "would not adversely affect but rather would benefit the public safety." *Id.* at 204a.

The district court also found that prison populations can be reduced safely and effectively by diverting members of two groups out of the state prison system: technical parole violators and low-risk offenders with short sentences. California returns an unusually high fraction of parolees to state prison, as compared with other states. Approximately 70,000 parolees are returned to prison in California each year, of which approximately 17,000 are "pure technical violators" who have not been arrested for a new crime but have only violated a term or condition of their parole. *Id.* They are sent to state prison for an average of only four months; while there, they are kept in crowded reception centers. *Id.* at 205a-206a. The court found, based on a careful review of the evidence, that "public safety would improve if technical parole violators who are not returned to prison were diverted to alternative sanctions in the community, including drug treatment, day reporting centers, electronic monitoring, and, if necessary, county jail." *Id.* at 208a.

In addition to technical parole violators, low-risk offenders with short sentences are promising candidates for diversion to community sanctions. Many prisoners enter the California prison system with sentences of less than 24 months, "the largest group of which are those with a sixteen-month sentence, many of whom have already served up to seven months of their sentence in a county jail." *Id.* at 210a. "Under current policies, these inmates can halve the remaining periods of their sentences by earning work credits, with the result that these inmates serve only a few months in state institutions – an amount comparable to that served by technical parole violators." *Id.* Instead of locking up *all* of these offenders, the state could "use risk assessment instruments to identify low-risk offenders and divert these offenders to community correctional programs to serve their sentences." *Id.* The evidence before the district court was that sanctions short of imprisonment can have deterrent value so long as they are "meaningful, immediate, and certain." *Id.* at 211a (internal quotation marks omitted). The court noted that programs that divert offenders from prisons to community-based sanctions or substance abuse programs had been used with success in Pennsylvania, Ohio, and Michigan. *Id.* at 213a. In light of all the evidence, the court found that "diversion of offenders to community correctional programs has significant beneficial effects on public safety and the operation of the criminal justice system as compared to the current system, including preventing the exposure of offenders to criminogenic conditions, providing effective rehabilitation, and avoiding disruption in the offender's life that creates re-entry problems upon release." *Id.* at 214a.

The district court took pains to point out that "many witnesses wrongly assumed that this court would require a sudden mass release of one-third of California's prisoners or a ban on accepting new or returned prisoners." *Id.* at 222a. The court emphasized that such an indiscriminate approach "was not proposed by any party, nor would it be approved by the court." *Id.* Accordingly, the court found that its prison crowding reduction order could be implemented without an adverse effect on public safety. As discussed further below, the court was correct.

II. PRISON POPULATION REDUCTION PROGRAMS CAN BE EXECUTED WITHOUT ADVERSELY AFFECTING PUBLIC SAFETY.

All available empirical evidence indicates that prison populations can be reduced without causing an increase in crime rates.[4] While incarceration can serve to incapacitate, deter, and rehabilitate some portion of the prisoner population, its overall effect on crime rates is small compared to other legal and social factors.[5] As a result, states that have similar incarceration rates often have dissimilar crime rates. Since 1994, crime rates have dropped significantly, to about the same rates as in 1970, when the nation had fewer than 200,000 prison inmates and the incarceration rate was only 96 per 100,000. Today, more than 1.6 million total prisoners are incarcerated, a rate of 504 prisoners per 100,000 persons.[6]

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[4] *See infra* notes 23-28.

[5] *See generally* FRANKLIN E. ZIMRING, THE GREAT AMERICAN CRIME DECLINE (2006).

[6] *See* HEATHER C. WEST, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, PRISONER INMATES AT MIDYEAR 2009 – STATISTICAL TABLES 2 (June 2010).

This evidence suggests that low crime rates can be achieved without high incarceration rates.

A number of states have reduced their prison populations by increasing parole grant rates, increasing good-time credits, and diverting low-risk offenders from prison. The research on those reductions shows either no increase or a decline in crime rates following reductions in prison population. Thus, according to the available empirical data, prison populations can be – and have been – reduced without an adverse effect on public safety.

A. Empirical Evidence Shows That Prison Populations Can Be Reduced Without Increasing Crime.

1. Declines in crime rates have accompanied reductions in incarceration rates.

Empirical evidence shows that incarceration's effectiveness at deterring crime depends on punishment being certain and swift, not on the length of incarceration.[7] Thus, incarceration rates can be reduced without an adverse effect on public safety. "Most scientific evidence suggests that there is little if any relationship between fluctuations in crime rates and incarceration rates."[8]

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[7] *See* Daniel S. Nagin, *Criminal Deterrence Research at the Outset of the Twenty-First Century*, 23 CRIME & JUST. 1, 12-15 (1998) (summarizing studies suggesting that certainty of sanction, not severity of punishment, has greater deterrent effect). "The hope that the presence of brutal prisons will deter law violators is as old as the invention of the prison itself. Contemporary supporters of longer sentences argue that longer and harsher punishments are necessary to deter crime by making criminals think twice before committing another crime. This notion simplifies and distorts the dynamics of criminal behavior. When most people commit a crime, they correctly believe that they will not be caught." THE JFA INST., UNLOCKING AMERICA: WHY AND HOW TO REDUCE AMERICA'S PRISON POPULATION 14 (2007) ("UNLOCKING AMERICA").

In a salient example for this case, the number of prisoners in state or federal custody in the state of California declined from 171,340 in 2006 to 168,286 in 2009.[9] During the same time period, the crime rate in California declined by 15% (from 3,640 per 100,000 to 3,094).[10] Furthermore, from 1994 to 2000, California reduced the number of prison sentences handed out by judges by 14%, and violent crime in California dropped by 34% during the same period.[11] This statewide trend of fewer incarcerations and less crime also was seen on a local level. For example, in the four years following the 2005 release of 56,000 Los Angeles County jail inmates to comply with a mandatory population cap, the crime rate in the county declined by nearly 15%.[12] Similarly, in San

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[8] UNLOCKING AMERICA at 8; *see also, e.g.*, RYAN S. KING ET AL., THE SENTENCING PROJECT, INCARCERATION AND CRIME: A COMPLEX RELATIONSHIP 4 (2005) ("INCARCERATION AND CRIME") (surveying states trends to find that, "[s]ince 1998, 12 states experienced stable or declining incarceration rates, yet the 12% average decrease in crime rates in these states was the same" for those states as states with increasing incarceration rates).

[9] *See* CALIFORNIA DEP'T OF CORR. & REHAB., AVERAGE DAILY PRISON POPULATION: CALENDAR YEAR 2006 (2007); CALIFORNIA DEP'T OF CORR. & REHAB., AVERAGE DAILY PRISON POPULATION: CALENDAR YEAR 2009 (2010).

[10] *See* CALIFORNIA DEP'T OF JUSTICE, CRIME IN CALIFORNIA 2009: ADVANCE RELEASE (2009).

[11] *See* MICHAEL JACOBSON, DOWNSIZING PRISONS: HOW TO REDUCE CRIME AND END MASS INCARCERATION 126 (2005).

[12] *See* Los Angeles County Sheriff's Dep't Crime Summary, http://file.lacounty.gov/lasd/cms1_148405.pdf (showing overall crime rate per 10,000 population decreasing from 219.24 in 2005 to 186.39 in 2009). "In 2005 the county was forced to release early 56,000 sentenced inmates, 46,000 male and 10,000

Diego from 1994 to 2000, the number of prison sentences decreased by 25% while violent crime dropped 43%.[13]

Evidence from around the United States is consistent with the experience in California: all across the country, states and localities have experienced decreases in crime rates at the same time they have reduced their prison populations. New York City experienced one of the largest declines in crime in the country at the same time as it substantially reduced its jail and prison populations.[14] Between 1993 and 2001, violent crime in New York City decreased by 64%, and homicides by 69% while its jail population dropped by 25% and the number of people sentenced to prison fell by 42%.[15] Between 2000 and 2009, the number of index crimes reported in New York City

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female, in order to comply with their jail population caps." California State Sheriffs' Ass'n, *Jail Overcrowding: A State and Local Crisis* (2006), http://www.calsheriffs.org/index.php/resource-center/cssa-library/jail-overcrowding-whitepaper.

[13] *See* JACOBSON, *supra* note 11, at 126. Although some analysts have attributed the dramatic reductions in serious crime and felony arrests in New York City to the introduction of new methods of policing, particularly the use of the computerized statistics program CompStat, *see id.* at 114-15, San Diego had the same experience without using New York's methods. *See also* Judith Greene, *Zero Tolerance: A Case Study of Police Policies and Practices in New York City*, 45 CRIME & DELINQ. 171 (1999) (describing San Diego's Neighborhood Policing Philosophy, which emphasizes both community policing and community participation, in contrast to New York City's "zero-tolerance" policy).

[14] *See* ZIMRING, *supra* note 5, ch. 6; JACOBSON, *supra* note 11, at 126.

[15] *See* JACOBSON, *supra* note 11, at 113; UNLOCKING AMERICA at 8 & n.19.

dropped 34.6%,[16] and at the same time the New York City Department of Correction inmate population decreased by 11.6%.[17] Statewide in New York between 2000 and 2009, the index crime rate dropped 25.4%[18] while the New York State Department of Correction Services inmate population fell by 18.5%.[19]

New Jersey likewise experienced declining crime rates contemporaneously with declining prison populations: the crime rate there fell 17% from 2000 to 2008, while the number of offenders sentenced to prison declined by 7%.[20] In fact, from 1992 to 2002, several states that had the lowest increases in prisoner population – including Illinois, Ohio, Michigan, and Massachusetts – also saw a substantial decrease in violent crime.[21] And nationwide from 1994 to 2000, 6% fewer people were sentenced to prison in state courts, yet violent crime dropped 23%.[22] As these examples show, fewer prisoners does not equal more crime.

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[16] *See* DIV. OF CRIMINAL JUSTICE SERVS., OFFICE OF JUSTICE RESEARCH & PERFORMANCE, CRIME IN NEW YORK STATE: 2009 FINAL DATA 5, app. 2 (2010).

[17] Between March 31, 2000, and December 31, 2009, the New York City Department of Correction inmate population decreased by 11.6%. *See* NEW YORK STATE COMM'N OF CORR., INMATE POPULATION STATISTICS (Oct. 2010)' ("NY STATE 2010 INMATE POPULATION STATISTICS").

[18] *See* CRIME IN NEW YORK STATE: 2009 FINAL DATA at 5, app. 1.

[19] Between March 31, 2000, and December 31, 2009, the New York State Department of Correction inmate population decreased by 18.5%. *See* NY STATE 2010 INMATE POPULATION STATISTICS.

[20] *See* Chris Megerian, *N.J.'s Inmate Population Declines; Officials Credit Less Crime, Prisoner Re-Entry Programs*, NJ.COM, July 18, 2010.

[21] *See* JACOBSON, *supra* note 11, at 127-28 & fig. 4.6.

[22] *See id.* at 126.

2. Moderate reductions in the length of imprisonment for selected prisoners can be implemented without compromising public safety.

In addition to studying the general relationship between crime and incarceration, criminologists have studied the effects of both shorter and longer periods of imprisonment on recidivism rates and crime rates. A growing body of evidence suggests that changing the average or median length of stay in a particular state is not associated with changes in either recidivism or crime rates.[23] Accordingly, efforts to lower prison population by reducing length of stay are not expected to affect public safety adversely.

In many states, good-time credits that prisoners receive for completing vocational and other rehabilitative services moderately reduce the period of certain inmates' confinement by a few weeks or months.[24]

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[23] *See, e.g.*, Anthony N. Doob & Cheryl Marie Webster, *Sentence Severity and Crime: Accepting the Null Hypothesis*, 30 CRIME & JUST. 143, 187 (2003) (reviewing research and finding "no conclusive evidence that supports the hypothesis that harsher sentences reduce crime through the mechanism of general deterrence"); CITIZENS ALLIANCE ON PRISONS & PUBLIC SPENDING, DENYING PAROLE AT FIRST ELIGIBILITY: HOW MUCH PUBLIC SAFETY DOES IT ACTUALLY BUY? 58 (2009) ("DENYING PAROLE") ("The data examined in this report show that people whose parole was delayed did not return to prison for new crimes at a much different rate than people released when first eligible.").

[24] *See* CHRISTINE S. SCOTT-HAYWARD, VERA INST. OF JUSTICE, THE FISCAL CRISIS IN CORRECTIONS: RETHINKING POLICIES AND PRACTICES 10 (2009) (citing new initiatives in Colorado and Oregon and tentative plans in Illinois and Ohio); John Cloud,

Jurisdictions that have used such programs have found that they reduce prison populations, lower recidivism rates, and reduce prison costs without increasing crime rates.[25] For example, Washington State expanded its earned-release program to increase opportunities for offenders who demonstrated good behavior in prison. An independent analysis of the program found that offenders were released on average 63 days early; measured against matched comparison groups, these offenders had a lower total recidivism rate, lower felony recidivism rate, and equivalent violent felony recidivism rate.[26]

These are not isolated results. Study after study has shown that prisoners released on an accelerated schedule do not recidivate more quickly or at higher rates compared to those who remain behind bars for the duration of their sentences. In one review of the relevant literature, drawing on data from 1981 to 2004, the authors concluded that there was "no significant difference in rates of recidivism among accelerated release and full-term prisoners" and that in some cases "early release prisoners had lower rates of recidivism."[27] An extensive study of prisoner

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Do Early-Release Programs Raise the Crime Rate?, TIME.COM, Sept. 14, 2009.

[25] *See infra* Part II.B.

[26] *See* WASHINGTON STATE INST. FOR PUB. POL'Y, INCREASED EARNED RELEASE FROM PRISON: IMPACTS OF A 2003 LAW ON RECIDIVISM AND CRIME COSTS, REVISED 6-7 (2009) ("INCREASED EARNED RELEASE FROM PRISON").

[27] CAROLINA GUZMAN, BARRY KRISBERG & CHRIS TSUKIDA, NATIONAL COUNCIL ON CRIME & DELINQUENCY, ACCELERATED RELEASE: A LITERATURE REVIEW 2 (2008). These findings are informing the decisions of corrections professionals. Michigan Department of Corrections spokesman Russ Marlan was recently quoted saying, "'If you look at all the research and data out

release in Michigan determined that "[s]erving more time does not decrease the chances of reoffending and may actually increase it."[28]

B. Empirical Evidence Shows That Increasing Incarceration Does Not Necessarily Enhance Public Safety.

1. Marginal increases in incarceration rates do not inevitably lead to marginal decreases in crime rates.

Empirical evidence also shows that linear or proportional reductions in crime rates are not achieved by increasing the size of the prison population. Intervenors attempt (at 22-23) to argue to the contrary by cherry-picking a handful of (mostly outdated) studies. But careful analysis of the empirical data reveals that, notwithstanding intervenors' protestations, there is no simple, direct relationship between incarceration rates and crime rates.

For example, in California in the 1980s, the state's incarcerated population increased more than threefold, and in the same period the crime rate dropped by about 15%. But an empirical study of these data found that decreased burglary and larceny offenses accounted for nearly all of the reduction in crime and that the reduction for all other offenses was "weak to negligible."[29] Moreover, the study's authors concluded that prison expansion's role in even the

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there, it shows there really is no connection between the amount of time served in prison and recidivism.'" John Agar, *Is Proposal To Allow More Michigan Prisoners Early Release Worth the Savings?*, MLIVE.COM, Mar. 2, 2010.

[28] DENYING PAROLE at 43.

[29] FRANKLIN E. ZIMRING & GORDON HAWKINS, INCAPACITATION: PENAL CONFINEMENT AND THE RESTRAINT OF CRIME 100-01 (1997).

15% decrease was dubious: arrest statistics showed that the drop related mainly to juveniles, who were less likely than adults to be locked up in the first instance.[30]

On the national level, one study concluded that the dramatic increases in incarceration rates from 1970 to 1990 accounted for only about 25% of the decrease in the nation's crime rate today.[31] Put differently, 75% of the decline in the crime rate was caused by something other than increased use of incarceration. Indeed, both the author of this study – as well as James Q. Wilson, whose work intervenors cite in support of their assertion of a linear relationship between crime and imprisonment – concede that incarceration has reached a point of diminishing returns.[32] Consistent with this view, the nationwide incarceration rate has risen steadily and dramatically since 1975, but the crime rate during that period has oscillated, rising to peaks in 1980 and 1991, declining throughout the 1990s, and remaining relatively stable during the last decade.[33]

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[30] *See id.*

[31] *See* William Spelman, *The Limited Importance of Prison Expansion*, *in* THE CRIME DROP IN AMERICA 97, 125 (Alfred Blumstein & Joel Wallman eds., 2006 rev.) ("Most of the responsibility for the crime drop rests with improvements in the economy, changes in the age structure, or other social factors. Whether the key to further reductions lies in further prison expansions, or (more likely) in further improvements in these other factors remains an open question.").

[32] *See id.*; James Q. Wilson, *Crime and Public Policy*, *in* CRIME 489, 502 (James Q. Wilson & Joan Petersilia eds., 1995) ("But lengthening the time served beyond some point will, like increasing the proportion of convicted criminals sent to prison, encounter diminishing marginal returns.").

Also telling is that those states with higher rates of growth in incarceration do not experience greater declines in crime.[34] In fact, the actual trend is that states with higher incarceration rates tend to have higher (not lower) crime rates. From 1991 to 1998, states that increased incarceration at *lower* rates experienced *greater* declines in crime rates than states that increased incarceration rates more.[35] The same phenomenon continued from 1998 to 2003, a period when states that decreased incarceration rates or held rates stable experienced the same reduction in crime as states that increased incarceration.[36] In New York State from 1991 to 2001, the incarceration rate increased by a modest 10.9%, while Texas's more than doubled, increasing 139.4%. Yet, during the same time, as crime rates were generally falling across the country, crime in Texas declined by only 34% while New York State's crime rate was cut in half.[37] In West Virginia, the incarceration rate rose by 5.1% from 2008 to 2009 – and during that period the state's violent crime nonetheless rose by 8.3%.[38] In Alabama between 2000 and 2009, despite relatively significant increases in prison population, the crime rate held nearly steady.[39] Within California, when San Francisco and Alameda counties lowered the number of state prison inmates in the 1980s, their crimes rates dropped at rates similar to those seen in California counties in which prison populations increased.[40]

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[33] *See* JAMES AUSTIN & TONY FABELO, THE JFA INST., THE DIMINISHING RETURNS OF INCREASED INCARCERATION – A BLUEPRINT TO IMPROVE PUBLIC SAFETY AND REDUCE COSTS 10 (2004); INCARCERATION AND CRIME at 7, fig. 5.

[34] *See* JENNI GAINSBOROUGH & MARC MAUER, THE SENTENCING PROJECT, DIMINISHING RETURNS: CRIME AND INCARCERATION IN THE 1990S 4 (2000).

[35] "The 'above average' states increased their rate of incarceration by an average of 72% and experienced a 13% decline in crime, while the rate of incarceration in 'below average' states rose by 30% and crime rates declined by 17%." *Id.*

[36] *See* INCARCERATION AND CRIME at 4.

[37] *See* AUSTIN & FABELO, *supra* note 33, at 12, tbl 4.

The disconnect between incarceration and crime rates can be seen in temporal comparisons as well as geographical ones. In New York City from 1993 to 2001, the city jail population dropped by 22% and the local trial courts imposed 47% fewer prison sentences, but violent crime decreased by 52%.[41] By contrast, 1985 to 1992 was a period of significantly increased incarceration – the number of prison sentences in New York City increased by 75% – but reported violent crime increased by 18%.[42]

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[38] *See* HEATHER C. WEST, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, PRISONERS AT YEAREND 2009 – ADVANCE COUNTS app. tbl. 1 (June 2010); FED. BUREAU OF INVESTIGATION, 2009 CRIME IN THE UNITED STATES tbl. 5 (Sept. 2010); FED. BUREAU OF INVESTIGATION, 2008 CRIME IN THE UNITED STATES tbl. 5 (Sept. 2009).

[39] Alabama's prison population increased 28.4% during this time period. *See* ALABAMA DEP'T OF CORR., FISCAL YEAR 2009 ANNUAL REPORT 54. Meanwhile, the crime rate rose or fell by small amounts each year, resulting in a 6% decrease overall from 2000 to 2009. *See* ALABAMA CRIMINAL JUSTICE INFO. CTR., CRIME IN ALABAMA 2009, at 8; ALABAMA CRIMINAL JUSTICE INFO. CTR., 2000 CRIME IN ALABAMA 14.

[40] *See* UNLOCKING AMERICA at 8 & n.21

[41] *See* JACOBSON, *supra* note 11, at 106, 122-23.

[42] *See id.* at 123.

All of these data are consistent with the observations of the American Bar Association's Justice Kennedy Commission. This Commission, charged with reexamining fundamental criminal justice issues, concluded that "[i]t is not even clear that the increased use of incarceration has enhanced public safety, although lawmakers for twenty years have acted in reliance on the claimed crime-preventive effect of harsh and certain punishments."[43] The crime-preventative effects of punishment are indeed unclear, and intervenors' claims to the contrary do not comport with the majority view held among criminologists.[44]

Intervenors' selective citation of studies claiming a linear relationship between incarceration rates and crime rates is thus of limited value to understanding the true public-safety impact of the three-judge district court's overcrowding reduction order. The studies cited by intervenors discuss data from an era – 1971 until 1993 – that began with low prison populations and rising crime rates. Specifically, the nation's prison population in 1971 was 198,061.[45] By 1994, the population had risen to more than 1 million.[46] In California, the prison population was 20,294 in 1971[47] and had increased to 125,179 by 1994.[48] Many violent and property offenders were imprisoned during this period. It is not surprising that there was a crime-reducing effect, as prosecutors were targeting society's worst offenders. Since 1994, incarceration rates have continued to rise – but via the increased incarceration of drug offenders, technical parole violators, and persons who previously would have been sentenced to probation.

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[43] JUSTICE KENNEDY COMM'N, AM. BAR ASS'N, REPORTS TO THE ABA HOUSE OF DELEGATES 20 (2004) ("KENNEDY COMM'N REPORT") ("Researchers are just beginning to explore the implications of the dramatic growth in incarceration rates for crime rates, for families and communities, for prison management, and for politics.").

[44] *See generally* Steven N. Durlauf & Daniel S. Nagin, *The Deterrent Effect of Imprisonment*, *in* CONTROLLING CRIME: STRATEGIES AND TRADEOFFS (Philip J. Cook et al. eds., forthcoming 2010); *see also* Daniel S. Nagin, Francis T. Cullen & Cheryl Lero Jonson, *Imprisonment and Reoffending*, 38 CRIME & JUST. 115, 178 (2009) ("[A] key finding of our review is that the great majority of studies point to a null or criminogenic effect of the prison experience on subsequent offending.").

Several studies more recent than those relied upon by Intervenors document the diminishing-return phenomenon. For example, an analysis of county-level data in Florida from 1980 to 2000 shows no statistically significant relationship between growth in prison populations and violent crime and property crime.[49] Another recent analysis of data from 1972 to 2000 finds that, in certain circumstances, imprisoning more people can increase crime.[50]

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[45] *See* U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS 1995, at 556, tbl. 6.21 (Oct. 1996).

[46] *See id.*

[47] *See* CALIFORNIA DEP'T OF CORR., CALIFORNIA PRISONERS: 1970 AND 1971, at 1 (1972).

[48] *See* CALIFORNIA DEP'T OF CORR., CALIFORNIA PRISONERS & PAROLEES: 1993 & 1994, at 1 (1996)

[49] *See* Tomislav V. Kovandzic & Lynne M. Vieraitis, *The Effect of County-Level Prison Population Growth on Crime Rates*, 5 CRIMINOLOGY & PUB. POL'Y 213, 234-36 (2006) ("This study finds no support for the 'more prisoners, less crime' thesis.").

Taken as a whole, these data make it clear that there comes a point after which the marginal benefit of increased incarceration diminishes. Indeed, in some circumstances, increased incarceration imposes marginal costs – that is, increased crime – rather than benefits.[51] In sum, as noted by the Kennedy Commission, the data "indicate that jurisdictions that incarcerate increasingly large percentages of their population are not necessarily any more crime-free than other jurisdictions."[52]

State *amici*'s reliance on wholly anecdotal evidence deserves even less credence than intervenors' flawed invocation of statistical studies. To the extent that there is anecdotal evidence of a temporary increase in arrests in the initial months of an early release, that temporary increase represents only a concentration in the total number of arrests that would have happened anyway. As the three-judge district court explained, "the weight of the evidence showed that, because length of stay is unrelated to recidivism, all else being equal the likelihood that a person who is released a few months before his original release date will reoffend is the same as if he were released on his original release date." JS1-App. 200a-201a. The court concluded that, although the timing and circumstances of a crime, if any, committed by a released inmate might be affected, the evidence indicated that the total number of such crimes would not change: "[w]hile the victims of crimes may be different, and we do not underestimate the significance of early release to those victims, our concern under the PLRA is to consider the overall impact on public safety, which we find would be no different." *Id.* at 201a.

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[50] *See* Raymond V. Liedka et al., *The Crime-Control Effect of Incarceration: Does Scale Matter?*, 5 CRIMINOLOGY & PUB. POL'Y 245, 269-70 (2006).

[51] *See* Joanna Shepherd, *The Imprisonment Puzzle: Understanding How Prison Growth Affects Crime*, 5 CRIMINOLOGY & PUB POL'Y 285, 285 (2006).

[52] KENNEDY COMM'N REPORT at 20.

2. Increased incarceration can increase crime.

The evidence cited above indicates that various methods of reducing the prison population can be implemented without putting the public at risk of higher crime rates. In addition, and as the district court recognized, there is evidence that high incarceration rates and long sentences, particularly combined with overcrowded prisons, actually can increase crime rather than avert it. There are two key ways in which this happens: First, the "criminogenic" nature of prisons can cultivate violence and criminality in offenders who might otherwise not have recidivated. The more people are subjected to this environment, the more widespread these effects will be. And the effects themselves become more severe as prisons become more crowded. Second, the disproportionate impact of high incarceration rates on particular communities can produce the kind of social consequences that lead to more crime. The parties and *amici* challenging the three-judge district court's order fail to address this kind of "adverse impact on public safety."

Being in prison increases an individual's proclivity toward future criminal behavior – the "criminogenic" effect of America's prison system.[53] Studies show that placing low-risk offenders in the same prison population as high-risk offenders increases the chances that the low-risk inmates will recidivate, suggesting that the low-risk individuals may be learning more serious criminal behavior from their fellow inmates.[54] As the three-judge district court noted, overcrowding in California's prisons has limited the state's ability to classify inmates according to their risk level and to segregate them effectively. *See* JS1-App. 189a. And a study of California's prisons found that "among those with a relatively limited criminal past – with little experience in the criminal justice system and few past offenses – placement in a higher-security prison appears to have a criminogenic effect on both cognitions and personality."[55] Furthermore, prison population density is correlated with increased violence as well as more frustration with a system that cannot provide sufficient resources for each inmate.[56] By reducing overcrowding in compliance with the court's order, and by diverting low-level offenders to alternative custody, California will be able to ameliorate these negative effects of incarceration.

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[53] *See* Martin H. Pritikin, *Is Prison Increasing Crime?*, 2008 WIS L. REV. 1049, 1056-57 & nn.30-38.

[54] *See id.* at 1055 & n.23.

[55] Amy E. Lerman, *The People Prisons Make: Effects of Incarceration on Criminal Psychology*, *in* DO PRISONS MAKE US SAFER? THE BENEFITS AND COSTS OF THE PRISON BOOM 151, 164 (Steven Raphael & Michael A. Stoll eds., 2009). The criminal personality factors assessed included impulsivity, absence of guilt, narcissism, dominant tendencies, risk-taking, violence, and aggression. The "criminal cognitions" measured included moral justification, refusal to accept responsibility, blaming the victim, and rationalizations. *Id.* at 162-64.

[56] *See* Pritikin, *supra* note 53, at 1058.

Beyond the effects on prisoners themselves, incarceration can lead to more crime in the communities from which those prisoners came.[57] By reducing incarceration rates and diverting low-risk prisoners to community-based sanctions, California can likewise reduce these social consequences and should see less crime as a result. Multiple studies confirm the obvious: increased unemployment is associated with more crime, particularly with property crimes.[58] People who have been in prison have drastically reduced employment opportunities.[59] Legal barriers may prevent former prisoners from holding certain jobs; employers may be reluctant to hire them; they may acquire behaviors in prison that are incompatible with adjusting to employment; and they may lose social connections that facilitate legitimate job opportunities.[60] "When age, education, school enrollment, region of residence and urban residence are statistically accounted for, past incarceration reduced subsequent wages by 11 percent, cut annual employment by 9 weeks and reduced yearly earnings by 40 percent."[61] This effect persists even when total work experience is statistically accounted for – meaning that it is incarceration itself and the stigma that follows from it, rather than time and experience lost while in prison, that drives unemployment of released inmates.[62] And, even if individuals can secure post-release employment, the financial effects of their previous incarceration may put them at an increased risk of recidivism, as available data suggest that a prison sentence carries with it an "earnings penalty"

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[57] *See generally* Jeffrey Fagan et al., *Reciprocal Effects of Crime and Incarceration in New York City Neighborhoods*, 30 FORDHAM URB. L.J. 1551 (2003). The authors closely examined the effects of incarceration across New York neighborhoods from 1985 to 1997. *See also* Dina R. Rose & Todd R. Clear, *Incarceration, Social Capital, and Crime: Implications for Social Disorganization Theory*, 36 CRIMINOLOGY 441, 467 (1998) ("High incarceration rates may contribute to rates of criminal violence by the way they contribute to such social problems as inequality, family life deterioration, economic and political alienation, and social disorganization.").

[58] *See* DON STEMEN, VERA INST. OF JUSTICE, RECONSIDERING INCARCERATION: NEW DIRECTIONS FOR REDUCING CRIME 11, tbl. 2 (2007) (collecting data from four studies showing a 10% increase in unemployment leads to a 10-16.6% increase in property offenses); Pritikin, *supra* note 53, at 1061 ("Research has consistently shown that inability to obtain steady, quality employment is one of the biggest risk factors for offender recidivism."); Harry J. Holzer, *Collateral Costs: Effects of Incarceration on Employment and Earnings Among Young Workers*, *in* Raphael & Stoll, *supra* note 55, at 239, 256 ("Our review of the empirical evidence suggests that, despite the mixed nature of the findings reviewed, the net effects of incarceration on employment and earnings are likely negative.").

[59] This effect is even more pronounced for racial minorities. *See, e.g.*, Devah Pager, *Double Jeopardy: Race, Crime, and Get-*

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ting a Job, 2005 WIS. L. REV. 617, 641-44 (finding that white job applicants with a criminal record are half as likely to be called back after a job interview as identical applicants without records, and that black applicants are one-third as likely). *See generally* DEVAH PAGER, MARKED: RACE, CRIME, AND FINDING WORK IN AN ERA OF MASS INCARCERATION (2007).

[60] *See* STEMEN, *supra* note 58, at 10; Michael Pinard, *Collateral Consequences of Criminal Convictions: Confronting Issues Of Race And Dignity*, 85 N.Y.U. L. REV. 457, 492-94 (2010) (detailing legal barriers to employment of former prisoners); Bruce Western et al., *The Labor Market Consequences of Incarceration*, 47 CRIME & DELINQ. 410, 412-13 (2001).

[61] BRUCE WESTERN & BECKY PETTIT, THE PEW CHARITABLE TRUSTS, COLLATERAL COSTS: INCARCERATION'S EFFECT ON ECONOMIC MOBILITY 11 (2010).

[62] *See id.*

of anywhere from 10% to 30%.[63] By diverting low-risk prisoners and technical parole violators out of the state prison system in a targeted manner and keeping these people closer to home with intermediate sanctions short of imprisonment, California's plan can be expected to reduce this prison-related unemployment and its after-effects.

Incarceration also has a long-term criminogenic effect by disrupting parent-child relationships. Parental incarceration disrupts child development and can lead to a host of negative effects on inmates' families. Obviously, children suffer from the economic consequences of their parents' imprisonment.[64] But they also tend to have more behavioral problems and poorer emotional well-being, meaning that incarceration can instigate or exacerbate a cycle of criminal behavior in subsequent generations.[65] Children with parents in prison may encounter stigma from their peers, and their performance in school tends to suffer. At the same time, their home environments are often destabilized by events such as geographic relocation or a new relationship on the part of the non-incarcerated parent.[66] All of this increases the odds that the children themselves will engage in criminal activity.[67] Again, diverting low-risk individuals to community-based sanctions rather than state prison can be expected to reduce these sorts of negative effects on children and their ultimate impact on public safety.

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[63] Western et al., *supra* note 60, at 424.

[64] *See* Pritikin, *supra* note 53, at 1065.

[65] *See, e.g.*, Rucker C. Johnson, *Ever-Increasing Levels of Parental Incarceration and the Consequences for Children*, *in* Raphael & Stoll, *supra* note 55, at 177, 194-202. Johnson's analysis isolates parental incarceration from other compounding factors that might contribute to children's behavioral and emotional difficulties. *See also* UNLOCKING AMERICA at 9-10 (citing evidence that parental incarceration is associated with higher rates of delinquency, mental illness, and drug abuse in children, as well as reduced academic success and employment prospects).

Thus, a properly designed and implemented prison population reduction program, like the one California has proposed, actually can contribute to a reduction in future criminal behavior by the prisoners themselves and by others in their communities. The parties and *amici* challenging the three-judge district court's order completely ignore the potential for this kind of positive impact on public safety.

III. CALIFORNIA'S PLAN FOR REDUCING PRISON POPULATION RELIES ON METHODS THAT HAVE BEEN SUCCESSFULLY AND SAFELY IMPLEMENTED ELSEWHERE.

The California plan for reducing prison population contains several elements that other jurisdictions have implemented (and, in some instances, that California itself had previously implemented) successfully to reduce overcrowding without compromising public safety. In particular, three features of California's proposal – using evidence-based risk assessment tools, enhancing opportunities for good-time credits, and diverting low-level offenders to places other than prison – have been proven successful in other states. This experience strongly supports the three-judge district court's conclusion that California's plan can be implemented without a significant adverse impact on public safety.

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[66] *See* WESTERN & PETTIT, *supra* note 61, at 21; Pritikin, *supra* note 53, at 1066.

[67] *See* Pritikin, *supra* note 53, at 1066-67.

A. California's Proposal Relies on Validated Risk-Assessment Tools for Decisionmaking.

In several ways, California's proposal incorporates empirically validated risk-assessment tools into the decisionmaking processes for offender placement, treatment, and release. For example, California proposes to use "summary parole" for offenders who meet a number of risk-evaluation criteria, including approval under the California Static Risk Assessment tool, which was validated by the University of California. 09-1233 JS App. 40a & n.7. The state would also base parole violation sanctions on the risk level of the individual, "placing parolees in the right programs and returning the high risk parole violators to prisons." *Id.* at 41a. A proposed alternative custody program would allow certain eligible inmates to serve part of their sentences in facilities outside of prison; the criteria implement a risk-assessment tool to identify those inmates with the highest likelihood of success in such circumstances. *See id.* at 63a-64a.

Many states have recognized the valuable role risk assessment tools can play in reducing recidivism.[68]

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[68] Additionally, a comprehensive policy framework report recently advocated expanded use of such tools. "Supervision and programs are most effective at reducing future crime when they (i) accurately assess offender risk and need, and (ii) use assessment results to assign supervision levels . . . and target programs to criminogenic needs." PEW CENTER ON THE STATES, POLICY FRAMEWORK TO STRENGTHEN COMMUNITY CORRECTIONS 7 (2008); *see also* MEGHAN GUEVARA & ENVER SOLOMON, U.S. DEP'T OF JUSTICE, CRIME & JUSTICE INST., NAT'L INST. OF CORR., IMPLEMENTING EVIDENCE-BASED POLICY AND PRACTICE IN COM-

In Michigan, for example, a key part of the state's recent Michigan Prisoner ReEntry Initiative ("MPRI") involves improving decisionmaking processes, and especially parole decisions, based on quality risk-assessment metrics.[69] The approach is paying off: where the MPRI model has been implemented, recidivism rates have been reduced by one-third.[70] Mississippi's experience has been similar. The state parole board last year adopted "a parole 'risk instrument' based on a generation of peer-reviewed research about which inmates are likely to recidivate and which aren't."[71] As a result, parole grant rates have nearly doubled, without a corresponding increase in crime.[72] Kansas, too, has seen the benefit of increasing the efficacy of correctional

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MUNITY CORRECTIONS 12 (2d ed. 2009) (recommending the corrections authorities "[d]evelop and maintain a complete system of ongoing offender risk screening/triage and needs assessments" as part of recidivism reduction strategy).

[69] "The MPRI Model involves improved decision making at seven critical decision points in the three phases of the custody, release, and community supervision/discharge process." MICHIGAN DEP'T OF CORR., 2009 STATISTICAL REPORT G-1 (2010) ("MICHIGAN 2009 STATISTICAL REPORT"). Michigan is using a dynamic risk assessment tool known as COMPAS. *Id.* at G-2. "At the state level, MPRI provides better training and more sophisticated assessment instruments for parole board members to raise their confidence in parole plans and expected outcomes, thus enabling higher parole approval rates." JUDITH GREENE & MARC MAUER, THE SENTENCING PROJECT, DOWNSCALING PRISONS: LESSONS FROM FOUR STATES 35 (2010).

[70] *See* MICHIGAN 2009 STATISTICAL REPORT at G-3 (citing a "33% relative rate reduction in total returns to prison" through May 2010, compared against 1998 baseline).

[71] John Buntin, *Mississippi's Corrections Reform: How America's Reddest State—and Most Notorious Prison—Became a Model of Corrections Reform*, GOVERNING (Aug. 2010).

[72] *See id.*

decisionmaking. As part of a 2007 statewide Risk Reduction Initiative, county-level probation supervision agencies received new risk-assessment training to help focus their efforts on the probationers most at risk for violation.[73] By doing so, the agencies were able to increase probation success rates from 46% in 2006 to 61% in 2008.[74]

Like each of these states, California can safely reduce its prison population in part through its proposal to base more decisions on validated risk-assessment instruments.

B. California's Enhanced Credit System Proposal Has Worked in Other States.

California's plan also is tailored to avoid undermining the deterrence effects that can be achieved through incarceration. As noted, empirical evidence shows that incarceration's effectiveness at deterring crime depends on the certainty and speed of imprisonment, not its length.[75] Thus the California proposal includes an accelerated-release initiative based on expanding the credit-earning system already in use. *See* 09-1233 JS App. 38a-39a. State after state has done the same thing with positive results.

New York's experience is particularly instructive because the state's "merit time" program has been in place since 1997. Merit time allows non-violent prisoners to qualify for earlier parole consideration by successfully completing education courses, substance abuse treatment, or extensive community service.[76] Prisoners who benefitted from the merit-time program between 1997 and 2006 returned to prison at a lower rate than prisoners who did not.[77] These long-term results parallel those observed in earlier but less extensive reviews of Illinois's enhanced good-time credit program.[78]

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[73] GREENE & MAUER, *supra* note 69, at 54-55. Prior to the 2007 initiative, an increasing number of parole revocations were for offenders classified as "low risk," suggesting that the previous assessment tool (or its implementation) was flawed. *See* JASON BRYL & TONY FABELO, THE JFA INST., KANSAS REVOCATION STUDY – FINAL REPORT: ANALYSIS OF PAROLE DATA FROM 2003-2005, at iii (June 2006).

[74] *See* GREENE & MAUER, *supra* note 69, at 55.

[75] *See supra* Part II.A.1.

Other states recently have replicated the positive results achieved in New York and Illinois. In 2007, Nevada increased the amount of good-time credits available to prisoners who complete education or treatment programs or demonstrate good conduct. The state also made parolees and probationers eligible for credit.[79] Nevada's prison population now is declining without compromising public safety. Indeed, from 2006 to 2009, violent crime in Nevada dropped 5% and property crime dropped 25%.[80] Similarly, Washington State's 2003 earned early release law allows eligible non-violent offenders to advance their release date by exhibiting good conduct and participating in work, education, or treatment programs.[81] As in New York, prisoners released under Washington's expanded earned-credit program have lower recidivism rates than other prisoners.[82]

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[76] *See* GREENE & MAUER, *supra* note 69, at 16.

[77] *See id.*

[78] *See* GUZMAN ET AL., *supra* note 27, at 7 (citing comparison of inmates awarded 90 versus 180 days of good-time credit that found "very little difference in the return-to-prison rates" between the two groups); MALCOLM C. YOUNG, SETTING THE RECORD STRAIGHT: THE TRUTH ABOUT 'EARLY RELEASE' FROM ILLINOIS PRISONS 19 (2010).

[79] *See* Report of James Austin, PhD, ¶ 33, Case No. 2:90-cv-00520-LKK-JFM, DN 3231-4 (Aug. 2008).

[80] *Compare* 2009 CRIME IN THE UNITED STATES, *supra* note 38, at tbl. 5, *with* FED. BUREAU OF INVESTIGATION, 2006 CRIME IN THE UNITED STATES tbl. 5 (Sept. 2007).

Like these other states that have successfully implemented accelerated release while reporting either no change or else actual reductions in recidivism and crime rates, California's plan uses modest sentence reductions and is targeted toward inmates who pose a low recidivism risk and who have demonstrated positive behavior while in prison.

C. California's Diversion Initiatives Have Worked Elsewhere.

In addition to accelerating release, California plans to reduce prison overcrowding through various diversion initiatives that will help keep low-risk offenders out of prison in the first place. The proposal calls for reentry courts aimed at assisting drug offender parolees through treatment, *see* 09-1233 JS App. 42a-43a, helping them avoid further incarceration for technical or substantive violations. It provides for alternative custody, using penalties such as house arrest and GPS monitoring for offenders who are eligible based on a risk-assessment metric. *See id.* at 63a-64a. Furthermore, the proposal would divert specific low-level offenders who are serving only a few months in state correctional facilities to county jails. *See id.* at 68a-69a. Beyond general crowding reduction, each of these reforms will preserve scarce prison resources for those who commit violent and property crimes. And they will limit low-risk offenders' exposure to the criminogenic conditions that can make them more dangerous upon their eventual release.

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[81] *See* INCREASED EARNED RELEASE FROM PRISON at 2.

[82] *See id.* at 7.

Similar reforms have been safely implemented elsewhere in the country. New York State has successfully used drug treatment as an alternative to incarceration since the 1990s.[83] Kansas adopted a comparable drug diversion program in late 2003;[84] a preliminary analysis of the outcomes showed that diverted offenders tended to have higher rates of successful termination and lower rates of technical revocation than other offenders.[85]

Both Michigan and Texas have diverted low-level offenders to alternative incarceration facilities, as California proposes, without putting the public at risk. Part of Michigan's MPRI model is the Community ReEntry Initiative, under which eligible parole or supervision violators are sent to county detention facilities rather than back to prison.[86] Similarly, in Texas, the 2007 Justice Reinvestment Initiative included a plan to house technical parole and probation violators in secure intermediate sanction facilities instead of revoking their supervision and sending them to prison.[87] There is no evidence that doing so has posed any public-safety risk.

Again, based on the documented experience of other states, California's proposal to implement diversion programs for low-level offenders should not adversely affect public safety.

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[83] *See* GREENE & MAUER, *supra* note 69, at 10-11 (surveying history of New York's "DTAP" programs).

[84] *See id.* at 51.

[85] *See* DON STEMEN & ANDRES RENGIFO, VERA INST. OF JUSTICE, KANSAS SENATE BILL 123: A PROCESS AND IMPLEMENTATION EVALUATION 61 (2006).

[86] *See* MICHIGAN 2009 STATISTICAL REPORT at H-1.

[87] *See* JUSTICE CTR., COUNCIL OF STATE GOV'TS, JUSTICE REINVESTMENT IN TEXAS: ASSESSING THE IMPACT OF THE 2007 JUSTICE REINVESTMENT INITIATIVE 4 (2009).

CONCLUSION

For the foregoing reasons, the Court should affirm the order of the three-judge district court.

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AMICUS
CURIAE
BRIEF

No. 09-1233

IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, et al.,

Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, et al.,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURTS
FOR THE EASTERN DISTRICT OF CALIFORNIA AND
THE NORTHERN DISTRICT OF CALIFORNIA

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INTEREST OF *AMICI CURIAE*

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *amici*, or their counsel, made a monetary contribution intended to fund its preparation or submission. The parties have given blanket consent to the filing.

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Amici also include the American Justice Institute, which was created in 1958 by world recognized correctional leaders and has been a source of independent information and policy recommendations for California correctional decisionmakers since its creation.

The bulk of the *amici* have direct ties to the California state prison system, both in terms of actual work experience and from having served as consultants to the CDCR in its internal reviews. They recognize the grave Eighth Amendment violations taking place within the State of California's prison system and understand, based on their decades of experience, that a crowding reduction order is necessary to remedy the ongoing constitutional violations. Further, *amici* are confident that crowding can be reduced without jeopardizing public safety. Therefore, *amici* present this brief in support of the appellees.

SUMMARY OF ARGUMENT

The order of the three-judge court requiring the State of California to limit prison populations to 137.5% of their capacity within two years is both a necessary and reasonable means to address the ongoing violations of California inmates' Eighth Amendment rights. Uncontrolled prison overcrowding in the California Department of Corrections and Rehabilitation (CDCR) system has, *inter alia*, denied inmates access to constitutionally-guaranteed levels of healthcare services. Despite repeated attempts by the CDCR and Governor Arnold Schwarzenegger to address the issue, no meaningful reductions in overcrowding have occurred to date.

When a prison population is allowed to expand so far beyond prison capacity, the effect is analogous to cancerous cells metastasizing in a healthy body. As the inmate population soars, the destructive effects are felt throughout the system – tensions rise for inmates, correction officers, and staff; violence increases; rehabilitation efforts are compromised; care for inmates is reduced; organizational ability is lost; the morale of both correctional staff and inmates plummets. In short, chronic overcrowding makes prison systems unmanageable, unsafe, and inhumane.

At its most basic level, overcrowding dilutes the scarce essential resources available inside a prison system. The number of cells and dormitories in the

California prison system are insufficient to meet prisoner demand, so prisoners are bunked three high in classrooms, laundry rooms, gymnasiums, and hallways. These spaces were never intended for the long-term housing of prisoners, nor are they suitable for the task.

Improvised housing areas like gyms and hallways make the work of correctional staff far more difficult and dangerous. Prisoners housed in such settings cannot be monitored effectively for health or disciplinary purposes. Placing too many prisoners in too small a space for too long without any effective means for monitoring prisoners and segregating the ill will inevitably lead to a heightened rate in the transmission of sickness and disease. Correctional staff charged with controlling these overcrowded environments are put at greater risk for infections and other health problems. In the event of a widespread prisoner disturbance or riot – the nightmare scenario in any correctional setting – these improvised confinement areas create an intolerably high risk of physical harm and death for correctional staff and inmates alike.

Chronic overcrowding not only forces prison systems to house prisoners in unsuitable areas – it also deprives the prison systems of the functions for which these spaces were originally intended. As a result, the prison system is doubly punished for overcrowding. Once a classroom or gymnasium is repurposed to house a prisoner population that exceeds planned capacity, there is less rehabilitative space available to the prison population – but even *more* inmates in need of such space. A growing inmate population will thus outstrip the system's available rehabilitative spaces at a significantly faster rate than even the growth rate for the inmate population. The loss of classroom and recreational space leads directly to a reduction in the availability of educational and other rehabilitative programs.

Chronic overcrowding's dilution of needed space and resources is only the outward manifestation of a larger problem. Close, crowded sleeping quarters, curtailment of rehabilitative programs, and the spread of sickness all work to dramatically lower the morale of an inmate population. This psychological effect does not require years of expert study to understand (although such studies have of course been done) *see* Gerald G. Gaes, *The Effects of Overcrowding in Prison*, 6 Crime and Justice 95 (1985) – just imagine having no personal space at any time, being forced to interact with dangerous strangers on a constant basis, being quarantined with the sick and diseased without adequate medical attention, and having few or no constructive outlets for your ambitions or your desire to improve your lot. Inmates in such a situation lose any hope for the prospect of rehabilitating themselves, becoming functioning members of society, or even making it out of prison alive and healthy. Inmates without hope or any constructive outlet for their energy will create more disciplinary problems and often become more violent. *Amici* have seen firsthand the demoralizing effect of chronic overcrowding and its resultant dangers.

Amici also have witnessed the lowered morale of correctional staff in the face of overcrowding. The role of the correctional officer depends fundamentally on the ability to maintain order. Overcrowding makes order more difficult to achieve. Chronic overcrowding can make maintaining order impossible. Without the ability to first create and maintain an orderly environment, the correctional officer cannot properly perform the other tasks within her purview. At the same time, the performance of these tasks becomes increasingly dangerous to the correctional officer. A correctional officer working in a chronically overcrowded environment will become more frustrated, tenser, and less invested in her work. Again, psychological studies are not required to understand this phenomenon – just imagine going to a job that did not contemplate success, but only incremental failure, and one that was physically dangerous as well. California's inability to retain needed CDCR staff is a testament to the demoralizing effect that chronic overcrowding has had on the State's correctional staff.

Chronic overcrowding is a cancer in the California prison system. It threatens the stability of the system and deprives those in it, both inmates and staff, of the resources and conditions necessary for success. *Amici* have seen the deleterious effects of chronic overcrowding. These effects are felt everywhere and at all times in the California system, but they are felt no more acutely than in the provision of medical and mental health care to inmates.

ARGUMENT

I. Prison overcrowding is a systemic threat to California prisons and the root cause of the constitutional deficiencies in the CDCR's provision of medical and mental health care to inmates.

As former corrections and law enforcement officials with combined decades of experience in correctional matters, *amici* have seen firsthand the harm caused by chronic overcrowding. Prison overcrowding is not simply another deficiency in the California prison system – it is the root cause of almost all the problems the CDCR faces. The direct causal relationship between overcrowding and the grievous state of medical and mental health care in the CDCR is undeniable.

The constitutional deficiencies in the CDCR's provision of medical and mental health care to inmates are well-established. It should be equally well-established that the unconstitutional deprivation of medical and mental health care services is the direct result of chronic overcrowding in California prisons. *Amici* have decades of firsthand experience overseeing entire prisons, including the provision of medical and mental health care to inmates. *Amici* have also witnessed the systemic harm caused by chronic overcrowding. For those with experience in the world of corrections, it is beyond cavil that overcrowding is the primary cause of the CDCR's constitutionally inadequate medical and mental health care.

The State does not contest the record's damning facts on the effects of overcrowding on medical and mental health care services in the CDCR: overcrowding prevents the proper screening of new inmates, resulting in undiagnosed medical and mental health conditions, JS1-App.87a-89a; overcrowding delays emergency response, or prevents it altogether, causing death, JS1-App.110a-111a; overcrowding increases the transmission of disease, JS1-App.101a-102a; overcrowding interferes with the distribution of medication to patient-inmates, JS1-App.112a-114a; overcrowding results in too few medical facilities to handle the inmate population in need of medical services, JS1-App.85a-95a; overcrowding has resulted in insufficient appropriate housing for inmates in need of medical attention, JS1-App.95a-97a.[2] That overcrowding negatively impacts healthcare services provided by the CDCR simply is undeniable.

California is far from the only state to have faced this issue, and the lessons learned in other jurisdictions are telling. When the Pennsylvania corrections system reached 150%-160% of capacity, overcrowding significantly affected the state's ability to provide adequate healthcare. Tr. 209:12; 210:1-5 (Beard). Only when crowding decreased, could Pennsylvania provide better healthcare to its inmates. *Id.* at 210:13-14 (Beard). Texas, too, has faced issues with prison overcrowding. As *amicus* Wayne Scott, former head of the Texas

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[2] Cites to "JS1-App." refer to the appendix filed by appellants in Case No. 09-416. Cites to "JS2-App." refer to the appendix filed in support of appellants' Jurisdictional statement in this case. The record in *Plata*, No. C01-1351-TEH (N.D. Cal.) is cited by docket entry (*i.e.*, "D.E. _"). Trial transcripts are cited as "Tr." and trial exhibits are cited by party and number (*i.e.*, "Def. Ex. __" and "Plf. Ex. __").

Department of Corrections, testified, overcrowding was once such an extreme and pervasive plague on the Texas prison system that it was deemed to constitute cruel and unusual punishment. *Id.* at 142:22-25 (Scott). Prior to undergoing two decades of court-ordered reforms, the Texas prison system reached capacity levels of 200%, which resulted in a dismal medical and mental healthcare system. *Id.* at 143:1-9 (Scott). As Mr. Scott testified, many of the same problems that existed in Texas exist now in California. *Id.* at 143:21-22 (Scott). Had the population remained unchecked, the Texas prison system would not have been able to remedy the constitutional violations relating to the inadequate delivery of medical and mental healthcare. *Id.* at 152:19-153:6 (Scott). Given the experiences of Texas and Pennsylvania, it is clear that population reduction is essential to remeding the current medical and mental healthcare crisis in California's prison system. *Id.* at 153:7-11.

Sadly, most of these problems are not new. Studies have been previewing the crisis in prison healthcare for decades. *See* Terence P. Thornberry and Jack E. Call, *Constitutional Challenges to Prison Overcrowding: The Scientific Evidence of Harmful Effects*, 35 Hastings L.J. 313 (Nov. 1983). Of particular concern is the CDCR's inability to effectively screen incoming prisoners – an essential component in maintaining a healthy and safe prison population. Overcrowded prison systems simply do not possess the resources to systematically screen and assess new inmates for medical and mental health problems. But even if new inmates could be properly assessed by correctional staff, the CDCR lacks the resources to provide prisoners with the needed treatment. Again, this crisis has long been foretold: "Unfortunately, the prospect of screening inmates for mental disorder and treating those in need of mental health services has become a daunting and nearly impossible task in the present explosion of prison growth." F. DiCataldo, A. Greer, & W. Profit, *Screening Prison Inmates for Mental Disorder: An Examination of the Relationship Between Mental Disorder and Prison Adjustment*, 23 Bulletin of the American Academy of Psychiatry and Law 573, 574 (1995).

Chronic overcrowding also results in unsanitary conditions where too many inmates are confined in too small a space. The spread of communicable disease and sickness become much more difficult to stop in such an environment. This is particularly true when prison systems run out of space to segregate healthy inmates from those known to be ill.

Once again, correctional officers have witnessed the effects of overcrowding and unsanitary conditions firsthand, and they are often put at risk by such conditions. According to the testimony of Gary Benson, a correctional officer at Folsom State Prison, "as many as 50 inmates at a time typically wait two to five hours inside a 12 by 20 foot holding area for medical or mental health treatment." Tr. 597:25-600:25 (Benson). He testified that he also regularly sees inmates in communal showers with bleeding, oozing, staph infections. *Id.* at 601:14-602:8; 603:23-604:24. Benson also testified that he contracted an antibiotic-resistant staph infection in July 2006 at one of the CDCR prisons. *Id.* at 605:1-606:4. Inmates with such infections are not segregated and these diseases almost always spread in prison. Only California's chronic prison overcrowding explains these outrageous conditions.

This litany of health deficiencies caused by overcrowding should be considered unacceptable from the standpoint of prison management. That the CDCR has been operating under these conditions for almost two decades is at once appalling and dispiriting to anyone with experience in and concern for our state prison systems. It is indicative of what has been called the California prison system's "ignoble distinction of systemic failure." Plf. Ex. 3, Letter from Chairman Michael E. Alpert to Governor Schwarzenegger and the California State Legislature. Dramatic action must be taken to strike at the heart of the two-decades-old broken health care system maintained by the CDCR. Taking steps to reduce California's inmate overcrowding is the only way back to a manageable prison system.

II. The conventional political system has failed to remedy the ongoing constitutional violations caused by the longstanding and persistent overcrowding of the California prison system.

As repeatedly noted by lead defendant Governor Arnold Schwarzenegger, the California prison system is seriously and dangerously overcrowded. In his October 2006 "Prison Overcrowding State of Emergency Proclamation," Governor Schwarzenegger warned that this overcrowding creates "conditions of extreme peril to the safety of persons and property." Plf. Ex. 1 at 8. All thirty-three CDCR prisons are at or above maximum operational capacity. *Id.* at 1. As

Governor Schwarzenegger proclaimed, "immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding." Plf. Ex. 1 at 6. Conditions are so bad that Governor Schwarzenegger declared a State of Emergency within the California prison system, a State of Emergency which remains in place today. *Amici* could not agree more with the Governor Schwarzenegger's assessment of the dire state of the CDCR.

A. Extreme overcrowding is a longstanding problem in the State of California prison system.

When Ronald Reagan was governor of California, the prison population was approximately 27,000 inmates. Since that time, the prison population has mushroomed. Until the 1980's, the California prison population increased at a relatively slow pace, with the population growing by an average of 500 inmates per year. Plf. Ex. 3 at 17. However, the population surged from 27,916 in 1980 to 99,145 in 1990, and the influx continued with the population reaching 161,000 in 2000. *Id.* at 18. From 1980 to 2006, the inmate population in California swelled 600%, increasing by an average of 5,500 inmates per year. *Id.* at 17.

By 2006, through a combination of factors, including population increases, sentencing laws, and parole policies, the total number of inmates reached an all-time high of 170,000. Plf. Ex. 1 at 1. In 2007, the CDCR convened an Expert Panel on Adult Offender and Recidivism Reduction Programming (hereinafter "CDCR Expert Panel") to examine ways to reduce recidivism by changing offender behavior. *See generally,* Plf. Ex. 4. After studying all aspects of recidivism, the Expert Panel's first recommendation to the California legislature was to reduce the dangerous overcrowding in California's prison facilities. *Id.* at viii. At that all-time peak, the CDCR was housing 172,385 prisoners in facilities designed to hold half that amount, with 18,000 inmates being housed in areas meant for programming and rehabilitation activities. *Id.* At a time when the largest prison in the CDCR system had a design capacity of 3,900 inmates, there were fourteen CDCR prisons housing over 5,000 inmates. Plf. Ex. 1 at 2-5. *See, also,* Department of Corrections and Rehabilitation, *Monthly Report of Population* (June 30, 2007), http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad0706.pdf. Several, in fact, held upward of 7,000 inmates. Tr. 213:25-214:10 (Beard).

California, to its credit, has convened more than a dozen blue ribbon panels over the past twenty years to examine its prison system. Each panel has concluded that the State must reduce prison crowding. JS1-App. 55a. However, the calls to reduce crowding have been largely ignored and the crowding worsened. As of September 30, 2010, the CDCR population was well over 164,000, barely dropping from its 2007 peak. Department of Corrections and Rehabilitation, *Monthly Report of Population*, (September 30, 2010), http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/ Monthly/TPOP1A/TPOP1Ad1009.pdf. According to a recent report by the United States Department of Justice, only Alabama rivals California's excess of inmate population relative to design capacity. U.S. Department of Justice, *Bureau of Justice Statistics Bulletin* at 44 (June 30, 2010), http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf. California's outlier status demonstrates the need for a drastic reduction in percentage capacity.

B. Lead defendant, Governor Arnold Schwarzenegger, agrees that overcrowding in California's prisons results in conditions that threaten the health, safety, and effectiveness of the California prison system as well as pose a danger to the community at large.

Uncontrolled overcrowding in the California prison system poses such a threat to the health and wellbeing of inmates and CDCR staff that in 2006 lead defendant Governor Arnold Schwarzenegger issued a Prison Overcrowding State of Emergency Proclamation. *See generally*, Plf. Ex. 1. The *amici* share the Governor's distress and dismay at the state of overcrowding in the California state prison system. As *amicus* Joseph Lehman, the Former Director of Corrections for Washington, Maine, and Pennsylvania, testified, space that would "otherwise [be] program space, such as education space, [was] filled with inmates in terms of dormitories, as well as recreations, gyms filled with beds and bunkbeds." Tr. 268:13-17 (Lehman). The level of overcrowding shocks even those *amici* that have previously grappled with overcrowded systems. *Amicus* Wayne Scott emphasized that "I have been in a lot of jurisdictions over the last five years, and I haven't seen this level of overcrowding in any of those jurisdictions." Tr. 144:23-25 (Scott).

Overcrowding poses a threat not only to the inmates, but also to the men and women who work inside the prisons. Plf. Ex. 1 at 1. The threats identified by Governor Schwarzenegger included the "increased and substantial risk of violence". *Id.* Tight quarters also impair the ability of the corrections officers to monitor the activities of prisoners. *Id.* at 2. In his 2006 Proclamation, Governor Schwarzenegger identified the overwhelming number of acts of violence both within the inmate population and against the CDCR staff that resulted from overcrowding. In 2005 alone, there were 2,642 acts of violence perpetrated by inmates against other inmates and 1,671 incidents of violence against CDCR staff. *Id.* at 6. Governor Schwarzenegger cautioned that similar overcrowding has led to deadly prison riots, a warning that rang true when California experienced prison riots in both 2008 and 2009.

It should come as no surprise that prison overcrowding results in increases in violence. Fights break out because inmates are constantly forced into tight quarters a result of the limited space. Inmates must compete for the limited toilet, shower, and sink facilities, often resulting in violence when basic hygienic needs must be met. As noted by *amicus* Wayne Scott, "decades of experience have demonstrated to me that close physical proximity, lack of adequate supervision, and competition for scarce resources are a recipe for violence in high-pressure prison settings." D.E. 1714-9 ¶ 32.

In addition to the threat of violence posed by significant and chronic overcrowding, overcrowding also subjects California prisoners to a high risk of serious injury and death because of the appalling health care system within California's prisons. Signs and symptoms of serious medical conditions are left unidentified because of overcrowding at prison reception centers. JS1-App. 87a-90a. The failure to properly treat and examine inmates continues inside the prison system due to overwhelmed medication management systems and medical records systems. JS1-App. 112a-114a, 118a-121a. Moreover, the limited medical staff simply cannot provide for the vast inmate population. JS1-App. 104a-109a. As *amicus* Joseph Lehman testified, overcrowding creates a "situation where the demand significantly outstretches the ability to respond to the healthcare needs, both in terms of timing and actual service." Tr. 270:15-17 (Lehman).

Overcrowding also delays and severely restricts the emergency response of prison staff to medical emergencies, leaving inmates vulnerable to both illness and violence. JS1-App. 110a-111a. As recounted by *amicus* Jeanne Woodford, former director of the California Department of Corrections, an inmate died from wounds incurred in the middle of a crowded gymnasium because the crowd prevented prison staff from knowing about the injury for several hours, let alone enabling them to provide emergency medical aid. Tr. 382:14-383:3 (Woodford).

The severity of the problem is not in dispute. Governor Schwarzenegger, *amici*, and most other rational observers agree that "immediate action is necessary to prevent death and harm caused by California's severe prison overcrowding." Plf. Ex. 1 at 6. *Amicus* Wayne Scott describes the epidemic of overcrowding as presenting a "crisis management situation." Tr. 144:9 (Scott). Governor Schwarzenegger recognized that "the overcrowding crisis gets worse with each passing day, creating an emergency in the California prison system." Plf. Ex. 1 at 8. He declared that "conditions of extreme peril to the safety of persons and property" exist in the CDCR prison system "due to severe overcrowding, and that the magnitude of the circumstances exceeds the capabilities of the services, personnel, equipment and facilities" of the CDCR. *Id.*

C. The State of California has been unable to relieve prison overcrowding or to bring the California prison system into compliance with the Eighth Amendment.

Despite nearly two decades of judicial and political uproar over the excessive crowding in the California prison system, the State of California has failed to remedy the system's Eighth Amendment violations. The California district court first found widespread violations of the Eighth Amendment in the delivery of mental health care fifteen years ago. JS1-App. 292a. In December 1995, the court appointed a Special Master to oversee the mental health care system within the California prison system. JS1-App. 288a. Since that time the court has entered over seventy-five substantive orders to bring the CDCR healthcare system into compliance with constitutional requirements. JS1-App. 292a. However, the system remains woefully short of meeting the requirements of the Eighth Amendment.

In 2002, California conceded that it had not remedied the violations to prisoners' Eighth Amendment rights and agreed to judicial oversight of the prison medical system. D.E. 68 ¶29. The State also agreed to undergo remedial measures in the 33 CDCR prisons. D.E. 68 at 3-4, 8-9. By 2004, the situation remained stagnant and the State agreed to further court-ordered relief, including efforts to reduce staffing shortages. D.E. 229. Despite court intervention, by mid-2005, "not a single prison" had complied with the 2002 remedial plan, and the State had utterly failed to comply with the 2004 order to add staff. D.E. 294 at 3. Citing the State's failure to bring the prison medical system up to constitutional standards, the district court put the prison medical care system into receivership in late 2005. D.E. 371 at 1-2.

The Receiver took office in April, 2006, at a time when the California prison system was at 200% capacity. JS1-App. 29a, 60a. The Receiver has acknowledged that overcrowding has "especially adverse consequences concerning the delivery of medical, mental health and dental care" and interferes with his ability to "successfully remedy the constitutional violations." JS1-App. 86a. That same year, prior to declaring the State of Emergency, Governor Schwarzenegger put forth two proposals to the California Legislature to address overcrowding, as well as called the Legislature into special session to review proposals from the CDCR. Plf. Ex. 1 at 8. The Legislature failed to act upon either of these proposals and failed to adopt any proposals of its own. *Id.*

In 2007, 2008, and 2009, the California district court gave the State every option to reduce overcrowding. JS1-App. 63a, 69a-70a, 286-287a; D.E. 2066. In 2009, Governor Schwarzenegger again attempted to alleviate inmates' Eighth Amendment violations, this time by proposing to reduce the prison population by 37,000 inmates over two years. D.E. 2258 at 9-10. Despite the pleas from the courts and Governor Schwarzenegger, the California Legislature refused to act.

The three-judge California district court entered its crowding reduction order only after countless attempts by the conventional political system failed to reduce crowding on its own. *Amici*, with their decades of experience, do not see a solution to the current Eighth Amendment violations in California's prison system that does not involve a reduction in prison population.

III. The three-judge district court order takes a measured and reasonable approach to remedying the constitutional violations arising out of overcrowding in California's prison system.

The order of the three-judge court requiring the State of California to cap prison populations at 137.5% of their capacity within two years is a measured and reasonable way to address violations of California inmates' Eighth Amendment rights. By reducing overcrowding, the order all but ensures that inmate access to CDCR healthcare services will improve, and likely will result in improvements in the quality of such healthcare. Importantly for *amici*, the order does not dictate what remedial measures the CDCR must take, but rather provides the CDCR with the flexibility to take the reasonable steps necessary to reduce inmate overcrowding without negatively impacting the operations of the State prison system or public safety. Moreover, absent the three-judge court's order, it is clear that nothing will be done to remedy the ongoing Eighth Amendment violations.

A. The three-judge court order allows the State of California ample flexibility to manage its prison system.

As *amici* well know, prison systems are highly complex institutions tasked with creating safe conditions for both prison employees and inmates, all the while ensuring that prisons fulfill their primary mandate to secure inmates within facility confines. This all must be achieved with limited resources in an environment that often is volatile and hostile. Moreover, the challenges faced by prison systems vary from facility to facility, meaning that prison administrators must have the flexibility to address issues in a manner best suited to a particular system or prison.

The three-judge court's order gives the CDCR the flexibility it needs to reduce overcrowding and remedy its violations of inmates' Eighth Amendment rights in ways that make the most sense for each facility. While the lower court caps CDCR prison population at 137.5% of prison capacity, it does not in any way seek to prescribe how the State of California should go about reducing prison overcrowding. JS1-App. 169a, 175a-185a. Further, the three-judge court refrained from dictating the population levels at individual prisons. This enables the State to pursue all available options to meet the court's order.

The State of California has already spent significant time and resources exploring options for reducing overcrowding. Plf. Ex. 1. According to the State's own studies, there are multiple ways that CDCR can comply with the three-judge court's order. For example, prisoners can be transferred to out-of-state or federal correctional facilities, so long as proper procedures are followed. JS1-App. 160a. California can also construct new, or expand existing, prison facilities to relieve overcrowding.

In addition, there are a number of policy options available to the State and CDCR that can help reduce overcrowding. For example, the State can provide additional incentives for communities to assist felony probationers abide by the terms of their probation, thereby reducing the rate of recidivism. D.E. 2258 at 3-4. The State can also provide prisoners with additional opportunities to reduce their sentences through good behavior. Additionally, recidivism rates can be reduced by prohibiting CDCR from returning certain low-risk parolees to prison for minor parole violations. Each of these options, or a combination thereof, are available to help CDCR meet its obligations to reduce prison overcrowding. The three-judge court's order allows CDCR to decide which options are best to achieve the ordered reductions in overcrowding.

Notwithstanding the flexibility provided in the three-judge court's order, the State argues that the order is not "narrowly drawn" and is not "the least intrusive means necessary to correct the violation." State Br. 40. *Amici* reject the notion that a more "narrowly drawn" order will provide a less intrusive means of reducing overcrowding. Any order that requires the State to take specific actions – rather than simply setting inmate population caps – will undoubtedly intrude on CDCR's ability to address the Eighth Amendment violations in ways that make the most sense for CDCR facilities.

Courts are not well suited to make policy decisions on which prisons should be expanded, which healthcare professionals should be hired or which parole policies should be enacted. That is best left to state legislators and prison officials, and that is exactly what the three-judge panel did: it set a goal that the evidence shows will remedy the Eighth Amendment violations and left the State and the CDCR to work out the specific ways that it will achieve that goal. Any order more constrictive would bind prison officials to court mandated actions that may not be appropriate for certain CDCR facilities, and could, in fact, negatively impact public safety if the State were forced to comply with the terms of an overly-detailed court order that might not be appropriate under the circumstances.

B. The three-judge court order will alleviate the CDCR's violations of inmates' Eighth Amendment rights.

The order of the three-judge court requiring the State of California to cap prison populations at 137.5% of their capacity within two years will remedy the Eighth Amendment violations suffered by individuals incarcerated in the CDCR system by improving prisoner access to quality medical and mental health services. *Amici*, through their knowledge and experience with both state correctional systems and the federal prison system, have reason to believe that the 137.5% target selected by the three-judge panel is reasonable. As demonstrated above, the primary cause of the violation of prisoners' Eighth Amendment rights is overcrowding in the CDCR system. By reducing overcrowding at the CDCR facility level, the three-judge court's order will reduce demand proportionally for healthcare services at those facilities. Reduced demand will improve access to healthcare providers at CDCR facilities by reducing the overwhelming numbers of prisoners at each facility seeking assistance from limited healthcare resources. Concomitantly, the reduction in demand will improve the quality of healthcare services by enabling CDCR healthcare providers to spend additional time assessing, diagnosing, and treating individual inmates.

Reduced overcrowding will improve the quality of healthcare services at CDCR facilities in a number of ways. Often, a prisoner's first exposure to the CDCR healthcare system occurs at a prison facility's reception center. This is where, in theory, CDCR healthcare providers would assess known and potential medical and mental health conditions; however, as the lower court found, "[c]rowding of reception centers at levels approaching 300% design capacity prevents the state from identifying the medical problems of entering inmates, and makes it impossible to provide necessary medical and mental health care to incoming inmates, who routinely remain in reception centers for more than sixty days and may serve their entire sentence there." JS1-App. 141a. As a result, prisoners' "health needs are not identified" and "cannot be treated." JS1-App. 89a. This is a significant issue, as the failure to identify "potentially serious signs and symptoms" is a leading cause of prisoner deaths. Exh. Def. Ex. 1107 at 6-8. In other words, reducing overcrowding at CDCR reception centers not only would improve access to quality healthcare, but would result in reductions in prisoner deaths – the ultimate goal of any healthcare system.

Overcrowding also detrimentally impacts the provision of healthcare services beyond the initial screening. At the most basic level, prison overcrowding creates a situation where the demand of inmates for healthcare resources outstrips supply. Such has been the case in the California prison system for years. JS1-App. 142a. There simply are not enough healthcare providers at CDCR facilities to adequately assess and treat inmates. JS1-App. 104a-109a. By reducing overcrowding, prison staff will be able to spend more time diagnosing and treating individual inmates, which undoubtedly will improve the quality of care afforded to such individuals.

By reducing overcrowding, CDCR will also help address another fundamental issue that restricts inmate access to quality healthcare: the high vacancy rate in CDCR healthcare positions. Healthcare professionals in California simply do not want to work in the overcrowded and dangerous CDCR system. JS1-App. 154a. For that reason, the three-judge court concluded, and *amici* concur, that ordering the State to complete additional hiring, without reducing overcrowding, would be ineffective. JS1-App. 154a-155a. By reducing overcrowding, and improving security, CDCR can begin to fill some of the vacancies in prison healthcare positions, which, too, will improve inmate access to healthcare.

Reducing overcrowding at CDCR facilities will also help to alleviate physical impediments to providing constitutionally adequate healthcare – namely, the lack of space in which to diagnose and treat inmates. As the three-judge court noted, ". . . CDCR's facilities lack the physical space required to provide medical and mental health care." JS1-App. 154a-155a. By reducing the number of prisoners at CDCR facilities, prison staff can reclaim common areas of prison facilities that have been converted into makeshift dormitories to accommodate severe overcrowding. These common areas can then be converted either back to, or into, healthcare facilities available to treat prison inmates.

In addition to the direct effects that reductions in overcrowding will have on the provision of health services at CDCR facilities, there are numerous indirect impacts that will improve healthcare conditions in the CDCR system. For one, reduced crowding leads to better prison security, which in turn results in fewer violent incidents resulting in injury. Overcrowding also results in prison administrators making increased use of lockdowns to control prison populations. JS1-App. 116a-117a. When a prison is in lockdown, inmates may be unable to leave their housing units for any reason, including to obtain treatment at prison medical facilities. In 2006, CDCR facilities had 449 lockdowns, which averaged 12 days per lockdown, including 20 lockdowns that were 60 days or longer. JS1-App. 116a. These lockdowns – necessitated in most cases by overcrowding – severely impact the ability of CDCR to adequately address inmate healthcare needs. Further, *amici* know first-hand that prison lockdowns are a daily challenge to the CDCR, both in terms of resources utilized to ensure compliance and as disruptive to the goal of rehabilitation. Plf. Ex. 4, Appx. F at 101.

In sum, reducing overcrowding will reduce the primary cause of California's failure to provide inmates with constitutionally adequate mental and medical healthcare. The order of the three-judge court capping CDCR's prison population at 137.5% of capacity will reduce overcrowding to levels sufficient for CDCR to ensure that prisoners are able to access constitutionally guaranteed healthcare services.

C. The three-judge court order gives substantial consideration to public safety.

Amici have dedicated their careers and, in many cases their lifetimes, to the protection of the public. Under no circumstances would *amici* file this brief in support of the three-judge court's order if that order did not properly consider public safety and the proper operations of the criminal justice system. As such, the *amici* are confident that the court's order is consistent with the promotion of public safety.

The trial record is replete with evidence that CDCR can reduce prison overcrowding, and remedy the violations of California inmates' Eighth Amendment rights, without adversely impacting public safety. JS1-App. 185a-256a. The three-judge court dedicated nearly ten days for trial, heard from dozens of witnesses, including several of the *amici*, and considered hundreds of exhibits related to this issue. JS1-App. 185a-186a. Certainly the lower court adequately considered the issue of public safety.

Moreover, by leaving it up to the CDCR to determine how best to achieve reductions in overcrowding, the three-judge court allowed the State to pursue policies best suited to protecting public safety. Those options are numerous and have been employed in dozens of jurisdictions throughout the country that have reduced their prison populations without any resulting impact on crime rates. Tr. 2103:20-2105:21; 2107:15-2108:17; 2108:19-2109:1, 2110:6-2111:8, 2111:10-21, 2112:17-20 (Dr. Krisberg).

One of the more successful ways to reduce prison population without adversely impacting public safety is to expand the use of so-called "good time" credits, which reduce an inmate's sentence for sustained compliance with prison rules or by participating in rehabilitative, education or work programs. JS1-App. 196a-204a. In fact, California, like most other states, already rewards inmates for such behavior. Cal. Penal Code §§2931, 2933. The CDCR Undersecretary of Programs, Kathryn Jett, testified that California rewards inmates for good behavior because such a program can reduce recidivism. JS1-App. 196a. *Amici* Joseph Lehman and Jeanne Woodford both have recommended expansion of the good time credit system as a way to reduce overcrowding without adversely impacting public safety. *See* Aug. 15, 2008 Lehman Report ¶ 13; Tr. 1326:21-1327:2, 1361:2-13 (Woodford). In addition to the *amici*, the Governor himself supports expansion of the good time credit system and provided for its expansion in both his 2008 and 2009 budget proposals, stating that good time credits "reduce inmate violence within the CDCR and will facilitate the inmate's reintegration into society." Plf. Ex. 780 at 18 (Governor's Budget, Special Session 2008-09); Jan. 16, 2009 Sturges Decl., Ex. A at 28 (2009-10 Governor's Budget).

Another option available to the State that would reduce prison overcrowding without impacting public safety is to implement a policy of sending certain low-risk parolees back to prison for technical violations of the terms of their parole only when those violations include the commission of a new crime. As the three-judge court noted, California has a very abnormal practice of sending a high number of technical parole violators to prison. JS1-App. 204a. The State estimates that, each year, more than 70,000 parolees are returned to prison for technical parole violations. *Id.* This occurs notwithstanding that the Governor, key State prison officials, and the State's Expert Panel support the diversion of technical parole violators. Plf. Ex. 238 at 178 (Governor proposal), JS1-App. 207a; Plf. Ex. 2 at 47-49, Appx. A at 77-79, Appx. E at 88-89 (State's expert panel report); JS1-App. 55a; Plf. Ex. 113 at 75-91 (Governor's Strike Team Report), JS1-App. 189a; Plf. Ex. 3 at 31 (California Little Hoover Commission), JS1-App. 53a; Plf. Ex. 4 at 122, 144-155 (Deukmejian Report), JS1-App. 54a; Hoffman Trial Aff. ¶¶ 18-25 (*Plata* Docket 1633) (State parole chief); Def. Ex. 1306; Tr. 1993:6-14 (State's public safety expert).

A third option would be to adopt policies that divert low-risk prisoners with short sentences. As noted by the three-judge court, a number of correctional and law enforcement experts opined that the diversion of low-risk offenders would not have an adverse impact on public safety or the operation of the criminal justice system. JS1-App. 210a. *Amici* share this view. By diverting low-risk criminals into substance abuse programs or correctional day centers, or tracking their behavior with electronic monitoring devices, the State can protect the public while reducing the number of convicted criminals being sent to already overcrowded prisons. JS1-App. 212a.

The State could also reduce prison populations without endangering public safety by investing in rehabilitation services available to prisoners in prisons and to parolees in the community. The president of the Chief Probation Officers of California, a defendant-intervenor in the case, testified that providing rehabilitative programs to probationers in local communities would by itself reduce the prison population by between 20,000 and 25,000 prisoners. D.E. 1747 at 9. As the three-judge court noted, several jurisdictions throughout California have already implemented such programs, which have reduced recidivism and thereby improved public safety. JS1-App. 215a. In other words, rehabilitative services not only reduce prison overcrowding, but they also improve the community by preventing crime.

In addition to these, the State has many other options – ranging from the construction of new prisons to the transfer of prisoners into other states' correctional facilities – that would reduce prison overcrowding without negatively impacting public safety. The three-judge court's order does not require the State to "throw open the doors of its prisons." JS1-App. 173a-174a. Rather, overwhelming testimony affirms that there are population-reducing measures that "either have no impact" on the recidivism rate "or reduce the recidivism rate" and therefore "would not adversely affect public safety." JS1-App. 249a; *see also* JS1-App. 196a-220a. By implementing these measures, CDCR can comply with the three-judge court's order to reduce overcrowding without negatively impacting public safety.

D. Judicial intervention is necessary where Eighth Amendment violations become as intractable as those in the California prison system.

All parties to this litigation agree that the overcrowding taking place in the California prison systems is without precedent. Such overcrowding not only restricts inmate access to healthcare, but also creates a dangerous environment for both CDCR staff and inmates, and impedes efforts to reform prisoners. While the CDCR has spent considerable time and money examining ways to reduce overcrowding, little progress has been made to date. This can largely be attributed to the failure of the California legislature to enact any meaningful legislation to reduce prison overcrowding, despite repeated pleas for help from Governor Schwarzenegger and more than a dozen blue ribbon panels that have studied the crisis. JS1-APpp. 61A; Int. Ap. 55a-56a.

The PLRA was enacted by Congress to address just this situation: where a court order "is truly necessary to prevent an actual violation of a prisoner's federal rights." H.R. Rep. No. 104-21, at 25 (1995); *cf.* 141 Cong. Rec. S14419 (daily ed. Sept. 27, 1995) (statement of Sen. Abraham) (noting that the PLRA permits "narrowly tailored order[s] to correct" constitutional violations and that the PLRA "allows the courts to step in where they are needed"). The Governor of California and the CDCR have attempted to remedy the constitutional violations occurring in State prisons for years, with no success, due to the refusal of the State legislature to enact needed reforms. *See generally*, Plf. Ex. 1. Overcrowding has reached such outrageous levels that the Governor was forced to declare a state of emergency, and still the legislature has not acted. *Id.* Clearly, the three-judge court order is necessary to remedy the ongoing violations of inmates' Eighth Amendment rights.

By affirming the order of the three-judge court, this Court will send a message not only to the California legislature, but to legislatures, governors and prison officials throughout the country, that severe prison overcrowding will not be tolerated when it infringes upon inmates' constitutional rights. This is precisely the message Congress was trying to send when it enacted the PLRA. By upholding the three-judge court's order and reaffirming Congress' intent to protect inmate rights, this court will ensure that prison systems across the country take seriously the threats posed by overcrowding, not only to inmate rights, but to prison employees and the community at large.

CONCLUSION

The order of the three-judge court should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, et al.,
Appellants,

vs.

MARCIANO PLATA AND RALPH COLEMAN, et al.,
Appellees.

Appeal from the United States District Courts for the Eastern District of California and the Northern District of California

BRIEF *AMICUS CURIAE* OF THE CRIMINAL JUSTICE LEGAL FOUNDATION IN SUPPORT OF APPELLANTS

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QUESTIONS PRESENTED

1. Whether the three-judge district court had jurisdiction to issue a "prisoner release order" pursuant to the Prison Litigation Reform Act ("PLRA"), 18 U. S. C. § 3626.

2. Whether the court below properly interpreted and applied § 3626(a)(3)(E), which requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right; and . . . no other relief will remedy the violation of the Federal right" before issuing a "prisoner release order."

3. Whether the three-judge court's "prisoner release order," which was entered to address the allegedly unconstitutional delivery of medical and mental health care to two classes of California inmates, but mandates a system-wide population cap within two years that will require a population reduction of approximately 46,000 inmates, satisfies the PLRA's nexus and heightened narrow tailoring requirements while giving sufficient weight to potential adverse effects on public safety and the State's operation of its criminal justice system.

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IN THE

Supreme Court of the United States

GOVERNOR ARNOLD SCHWARZENEGGER, et al.,
Appellants,

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MARCIANO PLATA AND RALPH COLEMAN, et al.,
Appellees.

BRIEF *AMICUS CURIAE* OF THE CRIMINAL JUSTICE LEGAL FOUNDATION IN SUPPORT OF APPELLANTS

INTEREST OF *AMICUS CURIAE*

The Criminal Justice Legal Foundation (CJLF)[1] is a non-profit California corporation organized to participate in litigation relating to the criminal justice system as it affects the public interest. CJLF seeks to bring the constitutional protection of the accused into balance with the rights of the victim and of society to rapid, efficient, and reliable determination of guilt and swift execution of punishment.

In this case, a dubiously constituted panel of three judges ordered a massive reduction in the number of felons who will be locked away. Both experience and common sense tell us that such an order creates a grave danger to public safety. Yet the panel gave little weight to the danger and easily credited claims that the reduction could (not necessarily would) be achieved without an adverse impact. This risk to innocent victims of crime, who have no ability to control how the reduction is to be implemented, is contrary to the rights CJLF was formed to protect.

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[1] The parties have consented to the filing of this brief.

No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae* CJLF made a monetary contribution to its preparation or submission.

SUMMARY OF FACTS AND CASE

This case arose from two separate lawsuits, presently titled[2] *Plata* v. *Schwarzenegger*, U. S. D. C. N. D., Cal. No. C01-1351 TEH and *Coleman* v. *Schwarzenegger*, U. S. D. C. E. D., Cal. No. CIV S-90-0520 LKK JFM. The *Plata* case involves health care, and the *Coleman* case involves mental health services in the state prisons of California. See Opinion and Order, JS1-App. 13a-14a, 30a-31a.[3] The *Plata* court appointed a receiver for the prison health care system, yet before the receiver had even issued his plan, the plaintiffs moved to convene a three-judge court for the purpose of considering a prisoner release order. See Brief of Appellants 14.

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[2] Both cases predate the tenure of the present Governor of California, and this Court's decision will likely follow it.

[3] For consistency across briefs, we adopt the document abbreviations from the Brief for Appellants 1, n. 1. The Appendix to the Jurisdictional Statement from the prior attempt to appeal in this case, No. 09-416, is cited "as 'JS1-App.' and the Appendix to the Jurisdictional Statement in this case as 'JS2-App.' The records in *Plata* . . . and *Coleman* . . . are cited by docket entry number (*i.e.*, '*Plata* D.E. __,' '*Coleman* D.E. __')." The Joint Appendix is not available as of the printing deadline for this brief.

On July 23, 2007, the two single-judge courts jointly called for the convening of a three-judge court for both cases, despite the lack of any statutory authorization for such a procedure. See *Plata* D.E. 780; *Coleman* D.E. 2320. The correctional officers' union intervened in the case on the side of the inmates. Counties, public safety officials, and state legislators intervened on the side of the State officials. *Plata* D.E. 857.

Trial was held a year and a half after the single-judge courts had issued their orders, but the three-judge court refused to admit or consider evidence regarding whether there were "current and ongoing" violations, asserting that the issue was not properly before them. See Coleman Motion to Dismiss 9. On August 4, 2009, the three-judge court issued an order that the state reduce its prison population to 137.5% of "design capacity." See Brief of Appellants 7-8. "Design capacity" is a term of art. The state corrections authorities have determined that the "maximum safe and reasonable capacity" is about 1.8 times "design capacity." JS1-App. 59a.

The defendants and intervenors attempted to appeal this order to this Court. The plaintiffs asserted that this Court had no jurisdiction because the August 9 order was not a "prisoner release order." Motion to Dismiss or Affirm in No. 09-416, p. 8.

On January 19, 2010, this Court dismissed. "Appeal dismissed for want of jurisdiction. The Court takes note that a further order has been entered in this case, but that order is not the subject of this appeal. It is also noted that the district court has stayed its further order pending review by this Court." *Schwarzenegger* v. *Plata*, 130 S. Ct. 1140, 175 L. Ed. 2d 967 (2010).

The order referred to was the order appealed in the present case, the "Order to Reduce Prison Population" issued by the three-judge court on January 12, 2010. Both the original defendant state officials and the intervenors appealed this order, in cases numbered 09-1233 and 09-1232 respectively. On June 14, 2010, this Court ordered in No. 09-1233, "Further consideration of the question of jurisdiction is postponed to the hearing of the case on the merits." No action was taken in No. 09-1232.

SUMMARY OF ARGUMENT

The whole case is properly before this Court in this appeal. Under the three-judge-court case law that was well established when Congress enacted the Prison Litigation Reform Act (PLRA) in 1996, once an injunction brings a case within this Court's appellate jurisdiction, the Court has the authority to resolve the entire case, including any predicates to the injunction. The language of PLRA does not require plaintiffs' piecemeal appeal theory, and the policy of PLRA is to the contrary.

The three-judge court erred in precluding evidence and consideration of whether there was an ongoing constitutional violation at the time of the prisoner release order and whether other remedies had been ineffective as of the date of the order. Although in some circumstances a three-judge court might have discretion to decline to reconsider an issue already litigated, this three-judge court's refusal on the theory it did not have the authority is reversible error.

This Court has the authority to require reassignment of the case to different judges upon remand. If there is to be a remand to the three-judge court, the circumstances of this case call for such a reassignment. The manner in which the three-judge court was created and the manner in which it has conducted these proceedings are more than sufficient to cause the public to doubt the fairness of the tribunal, which is a key consideration in those sensitive cases that Congress has assigned to three-judge courts.

ARGUMENT

I. The whole case, including all predicates to a prisoner release order, was properly before the three-judge court and is properly before this Court.

The *Coleman* plaintiffs aptly describe the three-judge court's view of the issues it had the authority to decide:

> "At a pre-trial conference, the three-judge court clarified the scope of its proceedings, emphasizing that its role was not to re-adjudicate the existence of the underlying constitutional violations found by the single-judge courts. The three-judge court made clear that if the State wanted to make the case that violations no longer existed, it should direct that argument to the single-judge courts. 2008-11-10 Pre-Tr. 28-29." Coleman Motion to Dismiss 9.

From this premise, plaintiffs assert that this Court has no jurisdiction to review the predicate decisions of the single-judge court, asserting that any appeal of those decisions must go to the Court of Appeals. *Id.*, at 18-19; see also Plata Motion to Dismiss 16 (adopting Coleman's argument on this point). Plaintiffs thus envision a single case parceled out between single-judge and three-judge courts, with two different appeal routes in the same case, one to this Court and the other to the Court of Appeals.

That is not the law, and the contrary proposition has been settled for a long time. Once a three-judge court is properly formed, it has jurisdiction of the whole case, not just the parcels of the case which required it to be convened. Once the three-judge court has issued an injunction that is appealable to this Court, this Court has jurisdiction to review the whole case, including any predicates to the injunction.

In *Florida Lime & Avocado Growers, Inc.* v. *Jacobsen*, 362 U. S. 73 (1960), the Court rejected the notion that the jurisdiction of the three-judge court was limited to the parts of the case that made the three-judge court necessary, leaving the remainder of the case with the single-judge court.

> "Cases in this Court since *Louisville & Nashville R. Co.* v. *Garrett*, 231 U. S. 298 (1913), have consistently adhered to the view that, in an injunction action challenging a state statute on substantial federal constitutional grounds, a three-judge court is required to be convened and has—just as we have on a direct appeal from its action—jurisdiction over *all* claims raised against the statute." *Id.*, at 80-81 (footnote omitted).

The three-judge District Court had jurisdiction over the whole case, and the whole case was properly before this Court once an appeal was properly taken.

> " 'The jurisdiction of the District Court so constituted, and of this Court upon appeal, extends to every question involved, whether of state or federal law, and enables the court to rest its judgment on the decision of such of the questions as in its opinion effectively dispose of the case.' " *Id.*, at 82, n. 8 (quoting *Sterling* v. *Constantin*, 287 U. S. 378, 393-394 (1932) (Hughes, C. J.)).

White v. *Regester*, 412 U. S. 755 (1973), is instructive on this point. A three-judge court found the reapportionment of the Texas House unconstitutional, but it only granted immediate injunctive relief against the plan as to two counties. *Id.*, at 759. The court held that once the appeal of the injunction properly brought the case to this Court, the appellants were also entitled to review of the declaration that the statewide plan was invalid, even though they could not have appealed that decision standing alone. *Id.*, at 760. "This declaration was the *predicate* for the court's order requiring Dallas and Bexar Counties to be reapportioned into single districts . . . ." *Ibid.* (emphasis added).

> "With the Texas reapportionment plan before it, it was in the interest of judicial economy and the avoidance of piecemeal litigation that the three-judge District Court have jurisdiction over all claims raised against the statute when a substantial constitutional claim was alleged, and an appeal to us, once properly here, has the same reach." *Id.*, at 761.

These cases predate the Prison Litigation Reform Act (PLRA), of course, but they were part of the legal background when PLRA was enacted. If Congress had intended for PLRA cases to have piecemeal appeals, contrary to previous practice, it would have said so expressly. There is no conceivable policy reason why Congress would have wanted piecemeal appeals, and such an intent should not be lightly inferred.

The question of whether the criteria of 18 U. S. C. § 3626(a)(3)(A) had been met initially was properly before the three-judge court, as was the question whether there was a current violation at the time that court issued the prisoner release order. These questions are also properly before this Court. Defendants contend that the questions should be characterized as jurisdictional. See Brief for Appellants 24-25. The line between jurisdictional questions and merits questions has been the subject of considerable confusion. See *Union Pacific R. Co.* v. *Locomotive Engineers*, 558 U. S.

__, 130 S. Ct. 584, 596, 175 L. Ed. 2d 428, 443 (2009). That characterization, however, does not determine the outcome. *Arthur Andersen LLP* v. *Carlisle*, 556 U. S. __, 129 S. Ct. 1896, 1901, 173 L. Ed. 2d 832, 839 (2009), noted that a decision that the Court of Appeals had no jurisdiction over a meritless appeal would reach the same result as accepting jurisdiction and then finding the appeal meritless. The subparagraph (A) question and the effect of the three-judge court's failure to address it are properly here for decision, jurisdictional or not.

II. The three-judge court's misunderstanding of its authority over the whole case is reversible error.

As described in Part I, *supra*, the three-judge court mistakenly believed it had no authority to revisit the holdings of the single-judge courts that the criteria of 18 U. S. C. § 3626(a)(3)(A) had been met initially or to determine whether they continued to be true at the time of the order. Even without considering the numerous other errors of the three-judge court, this error alone is sufficient to reverse.

Subparagraph (A) unambiguously states its criteria as conditions for a prisoner release order to be entered. Subparagraph (B) provides that only a three-judge court may enter the order. The statute was enacted with the case law background described in Part I, *supra*, that once a three-judge court is convened it has jurisdiction over the whole case, including any predicates. Neither the language nor the purpose of the statute implies that Congress intended to remove from the three-judge court the authority to consider whether the subparagraph (A) criteria remain true at the time of the prisoner release order.

Subparagraph (D) does, of course, provide for the single-judge court to find that the (A) criteria are met before calling for the three-judge court. That filter does not imply that the three-judge court is precluded from considering the same question. First, the three-judge court statute expressly says, "Any action of a single judge may be reviewed by the full court at any time before final judgment." 28 U. S. C. § 2284(b)(3). In every case, then, the three-judge court would at least have the discretion to reconsider the single judge's finding, even if it had only been entered the day before and there was no new evidence to consider. But there is more. Section 3626(a)(3)(A)(i) requires that the prior order for less intrusive relief "*has* failed to remedy . . . ." It is entirely plausible that the appointment of a receiver that *had* failed to remedy 30 months earlier[4] *has* achieved an acceptable level of compliance by the later date.

In the present case, plaintiffs maintain that they presented "overwhelming evidence" that violations of the Eighth Amendment are ongoing and therefore the prior orders have "failed to remedy" them to this day. See Coleman Motion to Dismiss 8. That may or may not be true. No finding to that effect has been made.

The three-judge court's statement that it made a finding in denying the State's motion for summary judgment, see JS1-App 77a (citing *Plata* D.E. 1757, pp. 6-7), is incorrect. The cited order rejects a challenge to the three-judge court being initially convened by referring to the findings of the single-judge courts, findings which necessarily referred to conditions then existing, not later conditions.

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[4] The order calling for a three-judge court was entered July 23, 2007, *Plata* D.E. 780, holding that the subparagraph (A) criteria were met as of that date. See § 3626(a)(3)(D). Subparagraph (A) itself requires that its criteria be met for the issuance of a prisoner release order, which was issued on January 12, 2010. JS2-App. 1a-10a.

This is not to say that every three-judge court must reconsider all the findings of the single-judge court in every instance. Particularly in light of the permissive "may" in § 2284, it would be within the discretion of that court, in proper circumstances, to decline to reopen a question already decided by another court, even if that court is one of lesser stature. Cf. *Darr* v. *Burford*, 339 U. S. 200, 215 (1950), overruled on other grounds in *Fay* v. *Noia*, 372 U. S. 391 (1963). In this case, though, the three-judge court did not exercise discretion. It mistakenly believed it had no authority to reconsider. Coleman Motion to Dismiss 9; Transcript of Hearing of Nov. 10, 2008, *Plata* D.E. 1786, pp. 28-29. Where the law provides a court with discretion, the litigant is entitled to have that discretion exercised.

In *Moore* v. *United States*, 555 U. S. __, 129 S. Ct. 4, 4, 172 L. Ed. 2d 1, 2 (2008) (*per curiam*), the defendant received a sentence for possessing cocaine base in accordance with the Sentencing Guidelines. That was a legal sentence, within the discretion of the District Court to impose. Nonetheless, it was reversible error for the District Court to impose that sentence while under the mistaken impression it had no discretion to depart. *Id.*, 129 S. Ct., at 5, 172 L. Ed. 2d, at 3.

So it is in this case. Before the extreme remedy of a prisoner release order can be entered, the three-judge court must determine, among other requirements, that prior remedies have been ineffective as of the date of the order. The court might properly rely on a prior finding by a single-judge court if it is recent and there is no reason to believe conditions have changed, but no such exercise of discretion occurred in this case.

Finally, the District Court made the remarkable assertion that a motion to terminate the previously granted relief under § 3626(b) was the exclusive method for asserting that the prior relief had succeeded in remedying the violations. See J51-App. 77a. No authority or supporting rationale is provided for this assertion. While the State *may* move for termination of a remedy which has proven effective, it would not necessarily be sound policy to do so immediately. Certainly nothing in the text or purpose of the PLRA supports the idea that Congress intended that the State forfeit its ability to challenge whether the criterion of § 3626(a)(3)(A)(i) has been met merely because it elects not to move for immediate termination of a less intrusive remedy.

The order must be vacated and the case remanded. If this Court accepts defendants' jurisdictional argument, then the three-judge court will be dissolved. If not, this Court must consider what directions to give regarding the three-judge court.

III. On remand, the case should be reassigned to a new panel.

A. Reassignment and Three Judge Courts.

Under 28 U. S. C. § 2106, this Court and other federal appellate courts have the authority to "require such further proceedings to be had as may be just under the circumstances." This statute gives the appellate court the authority to have a case assigned to a different judge on remand independently of whether the judge is disqualified under 28 U. S. C. § 455. See *Liteky* v. *United States*, 510 U. S. 540, 554 (1994). If the three-judge court is to continue, then the present case calls for the exercise of that authority.

No precedent of this Court spells out the circumstances in which reassignment should be ordered. However, *United States* v. *Robin*, 553 F. 2d 8 (CA2 1977) (*per curiam*), has been so widely quoted and followed throughout the Courts of Appeals that it comes close to being a national precedent. See, *e.g.*, *Maldonado Santiago* v. *Velazquez Garcia*, 821 F. 2d 822, 832 (CA1 1987); *Shcherbakovskiy* v. *Da Capo Al Fine, Ltd.*, 490 F. 3d 130, 142 (CA2 2007); *Armco, Inc.* v. *Steelworkers*, 280 F. 3d 669, 683 (CA6 2002); *United States* v. *Sears, Roebuck & Co.*, 785 F. 2d 777, 780 (CA9 1986).

> "Absent proof of personal bias requiring recusation, . . . the principal factors considered by us in determining whether further proceedings should be conducted before a different judge are (1) whether the original judge would reasonably be expected upon remand to have substantial difficulty in putting out of his or her mind previously-expressed views or findings determined to be erroneous or based on evidence that must rejected, (2) whether reassignment is advisable to preserve the appearance of justice, and (3) whether reassignment would entail waste and duplication out of proportion to any gain in preserving the appearance of fairness." *Robin*, *supra*, at 10.

In a case that Congress has assigned to a three-judge court, the second factor should have more than usual weight, and the third should have less. Three-judge trial courts are inherently cumbersome and expensive, and judicial economy was a major reason for Congress's severe curtailment of the three-judge court requirement. See E. Gressman, K. Geller, S. Shapiro, T. Bishop, & E. Harnett, Supreme Court Practice § 2.7, pp. 90-91 (9th ed. 2007). For the small class of cases that Congress retained or added later, Congress has implicitly decided to subordinate the factor of judicial economy.

Public confidence in the tribunal is the primary factor in the decision to require a three-judge court. Congress first created such a requirement in 1910 "to assuage growing popular displeasure with the frequent grants of injunctions by federal courts against the operation of state legislation regulating railroads and utilities in particular." *Swift & Co.* v. *Wickham*, 382 U. S. 111, 116 (1965). Popular discontent increased as social legislation expanded and *Ex parte Young*, 209 U. S. 123 (1908), provided a potent weapon for striking it down. *Swift*, *supra*, at 117. The three-judge court was created in the belief that the agreement of three judges that a state law was unconstitutional would meet with greater public acceptance than the decree of a single judge. See *id.*, at 118-119; *Florida Lime & Avocado Growers, Inc.* v. *Jacobsen*, 362 U. S. 73, 77-79 (1960). "The drafters of the original legislation thought three judges would be more sensitive to issues of federalism." Solimine, The Three-Judge District Court in Voting Rights Litigation, 30 U. Mich. J. L. Ref. 79, 120 (1996).

PLRA, like the acts described in *Swift*, arose from deep public dissatisfaction with the way the federal courts had handled prison litigation. See 142 Cong. Rec. S3703-40 (daily ed., April 19, 1996) (statement of Sen. Abraham). The three-judge court provision was considered among the "important new requirements," *id.*, at 3704, col. 3, to curtail the abuse. See also 141 Cong. Rec. S14414 (daily ed., Sept. 27, 1995) (statement of Senator Dole) (referring to "single-handed[]" action of federal judge).

A panel of three judges, *on average*, should provide "less opportunity for individual predilection in sensitive and politically emotional areas." *Swift*, 382 U. S., at

119; see also Solimine, 30 U. Mich. J. L. Ref., at 121-122. That is not *necessarily* the case, however. It is certainly possible for a panel to be comprised of three individuals whose "individual predilections" are in sync and well off to one side of the mainstream. When that happens, or when the public has substantial reason to suspect it has happened, the three-judge court requirement has failed in its essential purpose, and corrective action is required.

There are multiple reasons why the people of California can justifiably have grave doubts as to the fairness of the panel as presently constituted. They include: (1) the highly unusual, probably unprecedented, manner in which the three-judge court was invoked; (2) the chief judge of the circuit's evident disregard of the primary purpose of the three-judge court in making the selection of judges; (3) the court's unauthorized limitation of the issues properly before it and exclusion of evidence; (4) the court's handling of the public safety requirement of the statute; and (5) the court's manipulation of its orders to postpone this Court's review jurisdiction many months past the point where it should have attached, contrary to the purpose of the direct appeal statute.

B. The Unusual Manner of Formation of the Three-Judge Court.

The manner in which this particular three-judge court was formed was unusual and tends to detract from public confidence in the impartiality of the panel. Initially, the *Plata* litigation was not assigned to Judge Henderson by random assignment. In 2001, upon filing of the complaint, the plaintiffs filed a Notice of Related Case. *Plata* D.E. 2 (April 5, 2001). The "related" case was the *Madrid* litigation, which deals with a single institution, Pelican Bay, and deals with conditions generally, not only health care. See *Madrid* v. *Gomez*, 190 F. 3d 990, 993 (CA9 1999). Forty days later, Judge Henderson issued an order reassigning the *Plata* case from Judge Chesney to himself. Plata Docket Item 10 (May 15, 2001).

Amicus does not contend that this reassignment was improper in the sense of being a violation of the rules. It was, however, a deviation from random assignment on dubious grounds. Such deviations can create or contribute to an appearance of bias and cause a diminution of public confidence. See 145 Cong. Rec. 19410-19412 (1999) (statement of Sen. Specter).

The next step was far more unusual and far more troubling. After presiding over two separate prison conditions cases for years, Judges Henderson and Karlton held a joint hearing of two different district courts on the question of whether to convene a three-judge court. See JS1-App. 273a. The resulting order provided, "For purposes of judicial economy and avoiding the risk of inconsistent judgments, the Court recommends that this case be assigned to the same three-judge court convened to consider the issuance of a prisoner release order in *Coleman* v. *Schwarzenegger*, Case No. CIV S-90-0520 LKK JFM (E.D. Cal.)." *Id.*, at 286a; see also *id.*, at 304a.

There is no authorization in the law for such a procedure. PLRA contemplates that a single judge will call for the three-judge court. See 18 U. S. C. § 3626(a)(3)(C), (D). Then, the law contemplates that *the* judge (singular) who called for the court will be one of the three, and the "chief judge of the circuit . . . shall designate *two other* judges . . . ." 28 U. S. C. § 2284(b)(1) (emphasis added).

The danger of inconsistent judgments is a red herring. A denial of an injunction in one case does not preclude issuance in another based on the existence of different violations and a different need for and appropriateness of the remedy. If two panels came to inconsistent decisions on a question of law, the direct appeal to this Court would provide the definitive answer in short order in any event.

The law contemplates that the original judge, who has already decided a major point in favor of the plaintiffs, will be a minority of the panel, and two fresh viewpoints will be brought to the problem. This manipulation of the process, if accepted by the chief judge, guaranteed that the judges (plural) who called for the three-judge court would instead constitutes two-thirds of that court.

C. The Chief Judge's Appointment Order.

The appointment order by Chief Judge Schoeder shows no awareness that there is a problem. The order designates a circuit judge "to sit with" Judge Karlton and Judge Henderson without explaining why having both of them on the three-judge court is appropriate or consistent with the statute.

At this point, there were substantial grounds to fear that the process was being manipulated to deny a fair and unbiased tribunal to those who oppose a dramatic and large-scale forced reduction in the number of criminals removed from communities. Given these grounds, it was absolutely imperative that the chief judge choose for the third seat a circuit judge respected by law enforcement and public safety advocates. While it may sound idealistic to express confidence that all federal judges are fair and impartial, everyone knows the reality that " 'judges are not fungible.' " See *Laird* v. *Tatum*, 409 U. S. 824, 834 (1972) (Rehnquist, J., in chambers), quoting *Chandler* v. *Judicial Council*, 398 U. S. 74, 137 (1970) (Douglas, J., dissenting). "Individual predilection" does matter. Cf. *Swift*, 382 U. S., at 119. Given the two judges placed on the panel by the joint call maneuver, choosing the third to provide balance was vital to carry out the public confidence purpose of the three-judge court law. See *supra*, at 13.

Chief Judge Schoeder chose Judge Stephen Reinhardt.

To call this choice astonishing would be an understatement. Judge Reinhardt is nationally known for his disproportionate share of the decisions reversed by this Court. The cases include, just in the last several years, *Ford* v. *Hubbard*, 330 F. 3d 1086 (CA9 2003), reversed in *Pliler* v. *Ford*, 542 U. S. 225 (2004); *Belmontes* v. *Woodford*, 350 F. 3d 861 (CA9 2003), vacated in *Brown* v. *Belmontes*, 544 U. S. 945 (2005); *Belmontes* v. *Brown*, 414 F. 3d 1094 (CA9 2005), reversed in *Ayers* v. *Belmontes*, 549 U. S. 7 (2006); *Musladin* v. *LaMarque*, 427 F. 3d 653 (CA9 2005), reversed in *Carey* v. *Musladin*, 549 U. S. 70 (2006); and *Belmontes* v. *Ayers*, 529 F. 3d 834 (CA9 2008), reversed in *Wong* v. *Belmontes*, 558 U. S. __, 130 S. Ct. 1122, 175 L. Ed. 2d 931 (2009). Significantly, *all* of these reversed decisions erred in favor of the convicted felon; not a single one erred in favor of public safety.

Reversal, by itself, is no shame to the judge whose opinion is reversed. Legitimate differences of opinion can result in even the most competent and conscientious judges being reversed at times. See *Brown* v. *Allen*, 344 U. S. 443, 540 (1953) (Jackson, J., concurring in the judgment). However, a long string of reversed decisions, *always* in favor of the convict, raises legitimate doubts of fairness in the minds of those on the other side of the aisle.

If counsel for the prisoners could have chosen the panel themselves, this is very likely the panel they would have chosen. The central purpose of the three-judge court law was defeated by the appointment order.

D. The Decision and Order.

An additional issue of grave concern is the manner in which the District Court dealt with the public safety requirement of the PLRA. This issue is addressed in the Brief for Appellants and the Intervenor's Opening Brief, and we understand it will also be addressed in the brief for the *amici* States, so we will not duplicate that discussion here.

Finally, there is the manner in which the District Court manipulated its orders with the evident goal of postponing this Court's review as long as possible. The order of August 4, 2009, resolved all the major issues in plaintiffs' favor, decided there would be a prisoner release order, and decided how large the release would be. However, the court stopped just short of actually ordering release, enabling the plaintiffs to argue successfully that this Court's appellate jurisdiction had not attached. See *Schwarzenegger* v. *Plata*, 130 S. Ct. 1140, 175 L. Ed. 2d 967 (2010). The purpose of the statute providing for direct review in this Court is "accelerating a final determination on the merits . . . ." *Swift & Co.* v. *Wickham*, 382 U. S. 111, 119 (1965). The manner in which this determination was delayed smacks of an intent to defeat the public's right to prompt review.

For all these reasons, the people of California have reason to doubt the impartiality of the panel selected to hear this case. Assignment of new judges on remand would, of course, involve a substantial loss in judicial economy. However, given the magnitude of the case, the enormous amount of public funds at stake, and the potentially disastrous increase in victimization of innocent people if the court is wrong, that loss pales in comparison.

Ideally, it would be best to have an entirely new panel. *Amicus* must acknowledge, however, that 28 U. S. C. § 2284(b)(1) does provide that "the judge to whom the request [for a three-judge court] was presented, shall serve as [a] member[]. . . ." The mandatory word "shall" in a statute is not to be dismissed lightly. On the other hand, the statute refers to the original appointment and does not necessarily override this Court's reassignment authority under § 2106. If the Court decides that retention of one of the original district judges is required by § 2284(b)(1), then the prisoner population case can continue under either the *Plata* case *or* the *Coleman* case with the original judge from that case, that aspect of the other case can be stayed, and the chief judge of the Ninth Circuit can designate one new district judge and a new circuit judge to complete the panel.

CONCLUSION

The order of the District Court of January 12, 2010, and the predicate order of August 4, 2009, should be vacated. If the case is remanded to the three-judge court, the order appointing the judges should be vacated and the chief judge of the circuit directed to enter a new order, appointing a different circuit judge and at least one different district judge.

September, 2010

Respectfully submitted,

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AMICUS
CURIAE
BRIEF

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IN THE
SUPREME COURT OF THE UNITED STATES

◆

ARNOLD SCHWARZENEGGER, GOVERNOR OF CALIFORNIA, et al., *Appellants*,

v.

MARCIANO PLATA, et al., *Appellees*.

◆

On Appeal from Orders of the Three-Judge Court in the United States District Courts for the Northern District of California and the Eastern District of California

◆

BRIEF OF *AMICUS CURIAE* GREATER STOCKTON CHAMBER OF COMMERCE IN SUPPORT OF APPELLANTS

◆

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BRIEF OF *AMICUS CURIAE* GREATER STOCKTON CHAMBER OF COMMERCE IN SUPPORT OF APPELLANTS

The Greater Stockton Chamber of Commerce ("Chamber") respectfully submits this brief as amicus curiae in support of Appellants.[1]

INTEREST OF *AMICUS CURIAE*

Chamber, a non-profit corporation, includes over 1,680 business members who employ more than 40,000 employees in the Stockton, California area. Its members are taxpayers, voters, and residents of Stockton and San Joaquin County. The Chamber is vitally interested in the quality of life and economic opportunities available in Stockton and San Joaquin County. The central mission of the Chamber is to promote policies encouraging economic growth and opportunity while enhancing the quality of life in the community.

This Amicus Curiae brief is a tad unique when compared to the heightened legal standard of amicus briefs expected and enjoyed by this Court. The Chamber understands the overarching legal question posed by the review: did a federal court correctly apply an attenuated, exacting, and narrow statutory criteria, deliberately crafted to severely limit the opportunities for a federal court to turn Federalism and indeed Democratic principles on their collective heads, and allow an unelected federal receiver to exercise state legislative and executive powers without any meaningful accountability? The Chamber believes Congress understood the direct threat posed when a federal court usurps state law and public matters traditionally reserved to state and local governments and, as a result, why this Court should make clear that the statutory language shall be strictly applied and followed; therefore, federal intervention into venerated state matters should happen only in extraordinary and limited instances, instances which are simply not present here. The Chamber also believes the parties are fully capable of providing legal arguments and citations concern the underlying Constitutional issues triggered by this dispute.

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[1] Counsel for all parties have consented to the filing of this brief, and those consents have been filed with the Clerk of this Court. No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No one other than the amicus curiae, or its counsel, made a monetary contribution intended to fund its preparation or submission.

The Chamber, however, offers a unique perspective concerning the consequence to a local community after traditional notions of Federalism are obliterated, typical state and local responsibilities are usurped by a federal receiver, and the accountability subsumed by the ordinary give-and-take and checks and balances of the legislative and administrative process is omitted. The Chamber's story illustrates how federal intervention granted a receiver relative "immunity from normal democratic process" and why this is antithetical to the essence of Federalism. This brief highlights the Chamber's extraordinary and unprecedented fight against the federal courts and a federally appointed receiver unfettered by customary checks and balances. The Chamber's story vividly illustrates why this Court should enunciate a standard limiting opportunities for federal intervention into traditional state and local matters. Indeed, the Chamber's actual real world experience of fighting to protect the local community's quality of life and economic development against a threat posed by a federal receiver possessing a focused interest in locating a prison in a disadvantaged and under-represented community – without considering the long-term deleterious effects his decisions may have on the affected community – is relevant to understanding why Congress imposed a substantially difficult criteria to severely limit judicial activism into state and local affairs. While federal intervention into such affairs should not be as infrequent as a "camel (going) through the eye of a needle" [Matt. 19.24; Mark 10.25], the Chamber's lonely fight against a federal receiver persuasively explains why the statute should rarely be invoked by the federal courts.

The Chamber understands this Court frequently hears skilled advocates offer hypothetical adverse consequence that will occur should this Court rule one way or the other. Indeed these skilled advocates can depict hypothetical situations to illustrate the undesirable consequences of a federal district court too actively engaging in a state affair. However, the Chamber's advocacy is very different: it wishes to inform the Court of the *actual* consequences it experienced when a district court loosely applied the strict criteria intended to limit a zealous federal court's assumption of all or part of a state prison system.

In short, having been at the receiving end of this substantial disruption of the venerated and orderly relationship between the federal, state, and local levels of government, the Chamber believes the circumstances facing the Stockton community warrant a strict and narrow application of instances of federal takeovers of state prison systems. To put a finer point on it, tolerating a lax interpretation of the statutory standard strips local communities of protections ordinarily guaranteed by time honored Federalism safeguards designed to thwart overzealous government officials.

SUMMARY OF ARGUMENT

When a federal court fails to follow the heightened statutory criteria for ordering federal intervention into a state prison system, it potentially wreaks havoc on local communities by wrongly shifting direct and indirect costs of a state prison to local taxpayers. A federal receiver, fully supported by a federal court that appointed him or her, exercises state power with virtually no procedural accountability, is allowed unlimited access to state money, and has the power to ask the appointing court to waive any state regulation that may decelerate the speed of implementing his or her decisions.

This Amicus brief is intended to illustrate to the Court why a federal court's power to take over all or part of a state's prison system by injecting into the state system a federal administrator with a virtually unchecked ability to spend state money and the right to seek a full waiver any state law requirement should be severely limited as intended by Congress.

A federal district court's exercise of such far reaching and extraordinary power should be an available remedy in only the most extreme situations. It constitutes a situation hostile to traditionally understood notions of Federalism and the relationship between the federal, state, and local levels of government. In order to minimize the frequency of these situations Congress deliberately adopted a heightened standard that must be fully met before federal intervention into traditional state affairs can happen. In this instance this standard was not satisfied and, as a result, a local community faced a seemingly insurmountable battle against an unaccountable federal receiver.

ARGUMENT

I. THE CHAMBER'S STORY DEMONSTRATES THE NEGATIVE FORCE AND EFFECT ON A LOCAL COMMUNITY OF A FEDERALLY APPOINTED RECEIVER WITH UNFETTERED FEDERAL POWER AND ACCESS TO STATE RESOURCES.

A. Stockton.

Stockton, located in the San Joaquin Delta, is a fertile, agricultural area in California's heartland, well known for asparagus, cherries, walnuts and as the site of "Casey at the Bat." It is the thirteenth largest city in California and the sixty-second largest city in the United States.[2] It is primarily a blue collar, working class community, gradually transitioning from an agriculturally based community to the outer San Francisco Bay Area suburbs. According to the United States Census Bureau, Stockton is a majority minority city with 43.3% self-identifying as "white", 32.5% self-identifying as "hispanic or latino", 19.9% self-identifying as "asian", and 11.2% self-identifying as "black". Language other than English is spoken at 41.5% of Stockton households.[3] Stockton has twice been named an All-American City by the National Civic League. The Port of Stockton, the second largest inland port on the nation's west coast, imports and exports cargo to and from over thirty-seven different countries. The two main freeways that span the length of the Central Valley cut through Stockton, and are responsible for much of Stockton's growth and prominence as an important transportation/warehousing hub.

Nevertheless, Stockton faces monumental urban problems. It was an epicenter for the 2007 subprime mortgage melt down, with approximately one in ten homes in foreclosure. At the same time Forbes Magazine listed Stockton as the fifth most dangerous city in the nation.[4] Compounding Stockton's challenges, the unemployment rate at the time of preparing this Amicus Brief is approximately twenty percent. In short, the area faces economic challenges while contemporaneously needing to provide essential public services to increasingly needy residents at a moment when local tax revenues are declining.

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[2] http://quickfacts.census.gov/qfd/states/06/0675000.html.

[3] *Id.*

B. The Receiver.

In 2001, inmate Marciano Plata filed a class-action lawsuit against California's Governor and others ("Schwarzenegger"), alleging Constitutional violations in delivering medical care to inmates confined in California state prisons. ("Order Denying Defendants' Motion To Replace Receiver with Special Master and To Terminate the Receiver's Construction Plan," March 16, 2009 ("ODDM"), p. 1.) The parties stipulated for injunctive relief, which was entered as an order in June 2002. (ODDM, p. 1-2.) By the June 2002 Stipulation for Injunctive Relief, Schwarzenegger was ordered to implement new policies and procedures on a staggered basis, with seven prisons to complete implementation in 2003 and statewide implementation to be achieved by the end of 2008. (ODDM, p. 2.)

In May 2005, the lower court concluded the State was out of compliance with the stipulations and issued an order to show cause why Schwarzenegger should not be found in contempt and why a receiver should not be appointed to manage health care delivery for the California Department of Corrections and Rehabilitation ("CDCR"). (ODDM, p. 3.) In May and June 2005, the court conducted a six-day evidentiary hearing concerning the Order to Show Cause. (ODDM, p. 3.) At the end of June 2005, the court ruled it would take control of CDCR's medical delivery system and place a federal court appointed receiver in charge. (ODDM, p. 3.) In October 2005, the Court issued findings of fact and conclusions of law explaining the reasoning for the ruling. (ODDM, p. 3-4.) Concluding a contempt finding was unnecessary before appointing a receiver, the Court held the contempt remedy in abeyance. (ODDM, p. 4.) The Court initially appointed Robert Sillen as Receiver in February 2006, but subsequently replaced Mr. Sillen with J.Clark Kelso in January 2008 ("Receiver"). (ODDM, p. 4.) The Receiver's actions were reviewed by a panel of three District Court judges ("Judicial Panel").

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[4] "America's Most Dangerous Cities". *Forbes* (Forbes.com). 2009-04-23. http://www.forbes.com/2009/04/23/most-dangerous-cities-lifestyle-real-estate-dangerous-american-cities_slide_12.html.

The order creating a Receivership provided "[t]he Receiver shall exercise all powers vested by law in the Secretary of the CDCR as they relate to the Administration, control, management, operation, and financing of the California prison medical health care system. The Secretary's exercise of the above powers is suspended for the duration of the Receivership." (ODDM, p. 8, quoting the Order Appointing Receiver (OAR), Feb. 14, 2006, at p. 4.) Further, the OAR specifically authorizes the Receiver to seek a waiver of any or all state laws or regulations that impede the performance of his duties. Specifically, "if the Receiver finds that a state law...is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system, or otherwise clearly preventing he Receiver from carrying out his duties as set forth in this Order, or that other alternatives are inadequate, the Receiver shall request the Court to waive the state or contractual requirement that is causing the impediment." OAR at II.D. [5]

Schwarzenegger subsequently moved to terminate the Receivership and his construction plans, contending, as a legal matter, both the Receivership and the Receiver's construction plans were prohibited by the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626. (ODDM, p. 6.) Schwarzenegger also apparently made factual challenges to the Receivership and construction plans as well. (ODDM, p. 6.) On March 16, 2009, the district court denied Schwarzenegger's motion. (ODDM, p. 1, 7.)

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[5] This provision of the OAR supplied a clear and unmistakable chilling effect on the Chamber's vigor in protecting the community: it realized that any time it was "too successful" or "too aggressive" in challenging the Receiver's decision the Receiver could simply ask the Judicial Panel to take away the Chamber's state law based challenge and moot the litigation. The principle tool available to the Chamber, the California Environmental Quality Act (CEQA), expansively requires public agencies to study and mitigate adverse environmental effects to a community before approving a project. See, for example, *Bakersfield Citizens for Local Control v. City of Bakersfield* (2004) 124 Cal. App. 4th 184, 22 Cal.Rptr.3d 203 [even direct project economic impacts—overbuilding retail uses—may result in an indirect environmental effect such as urban decay].)

C. The Receiver Locates a Prison Hospital in Stockton.

Before undertaking a development project, such as a 1.2 million square foot prison facility, the California Environmental Quality Act ("CEQA")[6] requires environmental impacts from such construction be assessed, presented to the public, and mitigated if significant. And prior to approving a State project such as a prison hospital CDCR must comply with State environmental laws.[7] A State agency responsible for complying with CEQA cannot approve a project with significant impacts unless the impacts are mitigated and if not, then only if the agency adopts a statement concluding specific project benefits outweigh the impacts to the environment. Cal. Code Regs. Tit. 14, § 15093.

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[6] California Environmental Quality Act, Cal. Pub. Res. Code §§ 21000-21177; Cal. Code Regs. Tit. 14, §§ 15000-15387.

[7] *See* Cal. Code Regs. Tit. 14, § 15051(b)(1) ("The lead agency will normally be the agency with general governmental powers, such as a city or county, rather than an agency with a single or limited purpose such as an air pollution control district or a district which will provide a public service or public utility to the project."). Public participation "is an essential part of the CEQA process." *Id.* at §15200. The goal of CEQA is "maintenance of a quality environment for the people" and require all state agencies to give "major consideration…[to] preventing environmental damage, while providing a decent home and satisfying living environment for every Californian." Cal. Pub. Res.C. §21000. Hence, projects should not be approved if feasible alternatives or mitigation measures are present. *Id.* at §21002.

Here the federal Receiver selected a prison site in Stockton, prepared (under the supervision of a consulting firm he hired) his own Environmental Impact Report ("EIR"), certified this EIR, and personally decided to locate the prison just beyond the city limits of Stockton. Contrary to a well understood principle requiring EIRs to be prepared at an early stage of planning a public project to prevent CEQA from being rendered a meaningless post-hoc rationale (*Save Tara v. City of West Hollywood* (2008) 45 Cal.4th 116, 131, 84 Cal.Rptr.3d 614, 194 P.3d 344; Cal.Code Regs. Tit. 14 §15004), the Receiver expended considerable time and money planning the facility at Stockton before starting an EIR, thereby making bureaucratic momentum in favor of the Stockton site sizeable. In October 2009, the Receiver certified the Final EIR and immediately approved the prison project.[8] The EIR either ignored impacts to the local community or concluded state law prevented the Receiver from taking steps to lessen the severity of impacts identified as significant. In either case, the costs of this State project approved by the federal Receiver shifted from the State to the local community.

The Chamber provided extensive written comments about the EIR's deficiencies. In short the

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[8] *CHCF Stockton Project Approval*, 10/12/09, at pp. 7-9, 11-13, available at: http://www.cphcs.ca.gov/docs/projects/Stockton_FinalApprovalPacket_20091012.pdf.

Chamber complained the EIR ignored project-caused impacts to the local community; accordingly the solutions to these problems fell wrongfully and disproportionately on local government rather than State government. San Joaquin County and the City of Stockton provided parallel comments. The three entities were solid partners throughout the dispute.

Ten days before the 30-day CEQA statute of limitations ran to challenge his decision, the Receiver met with Chamber, City, and County representatives. He told the local officials he had visited Stockton infrequently, but offered that his daughter had attended several birthday parties at the local children's museum. He then explained the project would be constructed and operated even if local impacts caused by the State project were unaddressed. He also warned the group that he would refuse to negotiate with any entity filing a legal action challenging his decision. [9]

D. The Federal Receiver's Prison Construction Plan Posed Significant Impacts the Receiver Determined Not to Mitigate, Intending to Shift State Costs to the Local Community.

Community impacts from the Receiver's proposed 1.2 million square foot, 1,734-bed mental health prison hospital project were numerous and expressed by the Chamber, City, and County. Identified impacts raised by the Chamber, City, and County but ignored by the Receiver included:

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[9] This hardball tactic flowing from his expressed revulsion to civil litigation ranges from bizarre to silly. The Receiver, a full time law professor, teaches Remedies at University of the Pacific, McGeorge School of Law in Sacramento and can hardly claim his sensibilities are assaulted by thoughts of civil litigation.

- Human and Social Services. The Project would increase the need for various types of public assistance to prisoner families that would relocate to the area.

- Municipal Water and Sewer. The Project would impact Stockton municipal water and sewer services. Strangely the Receiver and the EIR incorrectly assumed Stockton would simply provide the prison facility with municipal water and wastewater disposal services in perpetuity and at little or no cost to the State. According to the Receiver, the capital costs of extending the services and the operational cost of providing the services would be paid by local residents and not the State.

- Traffic. Although the Receiver's EIR concluded the Project would generate significant traffic impacts on *both* city and county roads, it ultimately concluded the State did not have to pay for roadway *improvements required* to lessen traffic congestion created by the project.

- County Hospital. The Receiver's EIR assumed the prison project would make substantial use of the County hospital even though this facility lacked a secured ward and therefore could not safely admit felons for medical treatment.

- Public Safety Services. The project would demand significant local law enforcement and coroner services – with no provision for funding such services.

- Local Hospitals. Since the State salaries are greater than salaries for allied health professional in the area, existing hospital employees would migrate to the state facility leaving current medical facilities understaffed and depriving local non-incarcerated residents of access to local health care.

- Local Hire. Though the Receiver touted the alleged job-creation benefits of the project, the project offered no programs to assist local residents or vendors to receive any of the jobs, construction or permanent, or compete for supplying goods needed by the Project.

E. The Chamber, with the City and County, Sues the Receiver.

Facing a recalcitrant Receiver and lacking a viable option, the Chamber decided to preserve its objections and challenge the Receiver's decision certifying the EIR within the short limitations period. Stockton and San Joaquin County also joined the petition.[10] At a Chamber executive board meeting the underfunded Chamber figuratively passed the hat among the executive board members to raise sufficient funds to pay the lawsuit's filing fee. A Stockton law firm, founded by two former Chamber presidents agreed to represent the Chamber without pay. (The Chamber is not aware of any other instance in California where local interests have directly challenged the Receiver for failing to comply with controlling state law.)

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[10] *Greater Stockton Chamber of Commerce, et al. v. J. Clark Kelso, et al.*, San Joaquin County Superior Court Case No. 39-2009-00230310-CU-WM-STK (Filed Nov. 17, 2009)

After the lawsuit was filed by the Chamber, City, and County, the Receiver refused to meet with the three parties, except for one non-judicially supervised settlement meeting mandated by CEQA. Without prior notice, the Receiver unilaterally removed the case to Federal court.[11] The case was assigned to Judge William B. Shubb, but without prior notice the assignment mysteriously shifted to Judge Lawrence K. Karlton, a member of the federal Judicial Panel to which the Receiver answers. [12]

The Receiver suffered various mishaps in the litigation. First, the record of proceedings the

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[11] *Greater Stockton Chamber of Commerce v. Kelso*, Case No.: 2:09-CV-03308-LKK-JFM (E.D. Cal.).

[12] The Receiver further attempted to frustrate the local concern by demanding an unprecedented deposit amount of approximately $70,000 to prepare the administrative record. Generally speaking, CEQA challenges are tried with only a record of proceedings as admitted evidence. This bill was more than double the amount of an excessive deposit challenged in California state court published opinions. *See Wagner Farms Inc. v. Modesto Irr. Dist.*, 145 Cal. App. 4th 765, (2006) 52 Cal.Rptr.3d 683.

Receiver proposed preparing omitting key documents undermining the legal sufficiency of the EIR and a dispute erupted over excluding these damaging documents. Second, the Chamber's motion to remand the matter back to the State court was temporarily suspended when it was learned that the Receiver was operating under a suspended California corporation. The Receiver set up the corporation to house his activities but the corporation disobeyed California corporate regulations and consequently the Secretary of State suspended the corporation's right to conduct business. The Receiver ignored written notice from the State requesting he cure the problem. Since the Receiver's suspended corporation technically certified the EIR an open question existed over the validity of this action by a suspended corporation. This legal mistake is puzzling. In the course of the dispute the Chamber encountered a plethora of law firms representing some aspect of the Receiver's efforts to site a prison hospital in Stockton. [13]

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[13] In fact, during a hearing on the Chamber's motion to remand approximately thirteen attorneys attend on behalf of the Receiver and CDCR. The Chamber points this out merely to underscore why federal intervention into a state affair needs to be warranted by an extraordinary event. The Receiver was appointed by a federal court but seemingly enjoyed unlimited and unaccounted access to State money. All of the attorneys working for the Receiver were being paid from State revenues at a time the State faced a budget crisis, threatened to suspend vital government services, and was refusing to make vendor payments and other payments to needy citizens. Yet the Federal judiciary, unfettered by the magnitude of California's economic mess, impliedly determined California budget priorities by compelling State spending on new prison medical facilities, including the services of several law firms to help the

F. The Parties Discuss Settlement.

As the litigation bogged down, for the reasons explained below, the Receiver essentially clogged the lines of clarity by using more State money to hire a former State Senator, the Lieutenant Governor's son, and a politically connected Sacramento law firm to arrange for members of the Stockton business community to persuade local elected officials to withdraw the City and County as parties to the lawsuit. This lobbying effort failed. Yet the Receiver still refused to meet with the Chamber, City, and County.

Faced with a contentious and unresolved dispute about the completeness of the record of proceedings, a threatened appeal by the Chamber of the district court's denial of the Chamber's motion to remand the lawsuit to the state court, the district court's refusal to set a briefing schedule and hearing date on the Chamber's petition until the record dispute was resolved, and the federal Judicial Panel's denial of the Receiver's request to extend the time to open the Stockton hospital prison, the Receiver returned to Stockton and announced he was prepared to meet and negotiate with the Chamber, City, and County in order to settle the litigation.

Negotiations between the parties started on January 8, 2010 and ultimately culminated in

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Receiver, to the detriment of public education and health and safety funding needs.

executing a settlement agreement at the Chamber office on August 2, 2010 ("Settlement Agreement").

G. The Settlement Agreement.

The Settlement Agreement provides for mitigation of many but not all of the impacts facing the local community caused by the prison hospital. In particular, the Receiver agreed to fund improvements at the County hospital to facilitate sick inmates, agreed to pay for coroner services, agreed to mitigate County and regional, but not City traffic impacts, arranged for the point of sale for sales tax purposes to be the County, agreed to pay to extend water and sewer service to the prison facility, agreed to pay the facility's fair share operational cost for water and sewer service, agreed to local hire and local vendor programs, and agreed to form meaningful citizen review committees to review and advise the State about the prison facility's operational impacts to the community.

The Settlement Agreement, however, omitted several important items, including the facility's indirect demand for additional local law enforcement, the facility's impact to City streets, and any safeguard against the facility hiring substantial numbers of local health care workers from existing hospitals.

The development project, a prison hospital, agreed to mitigation measures commonly and ordinarily imposed on all California developments. In fact, the prison hospital project actually is financially responsible for *less* than an ordinary development project would be obligated to provide. To put a finer point on it, the litigation ultimately forced the Receiver to the bargaining table to compel the project to pay for most but not all of the impact it was causing to the local community. However, in the final analysis, the Receiver's mitigation agreement was substantially less than the mitigation package for which a private development in California would be responsible at the time of approval. Why? Because the Chamber, City, and County feared a continued failure to observe Federalism might operate to excuse the Receiver – acting as the CDCR – from mitigating any local impacts.

II. THE CHAMBER'S STORY REVEALS THE IMPORTANCE OF UPHOLDING THE HEIGHTENED STATUTORY CRITERIA EXPRESSED IN THE PLRA SO AS TO AVOID UNDUE BURDENS ON LOCAL COMMUNTIES AND TO PRESERVE THE NATION'S DELICATE AND TIME-HONORED BALANCE OF FEDERALISM AND SEPARATION OF POWERS.

The PLRA expressly limits instances where the federal judiciary actively administers State prisons. Congress was sensitive to this delicate balance of federal and state power and the inchoate awkwardness of federal judges operating a state prison program, spending state money and determining state budgetary priorities, and therefore adopted a comparatively high threshold before federal courts could intervene into State matters and essentially perform state legislative and executive functions. Even if the threshold is achieved, the relief granted "shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626 (a)(1)(A).

The Chamber's actual experience underscores the magnitude of Federal intrusion into fields traditionally occupied exclusively by state and local governments. Siting a state prison hospital involves satisfying countless state and local environmental and land use regulations and requires an elected State Legislature to determine state funding priorities within a legislative procedural framework typically involving numerous legislative hearings and comprehensive evaluations by qualified legislative staff members. The Receiver's truncated process produced a funding mechanism requiring Stockton and the County to disproportionately pay for the State's cost of building and operating the facility. This shifting of a State cost to local government amounts to a "wealth transfers to be achieved that could not be achieved otherwise; but rather that it permits them to be achieved 'off-budget,' with relative invisibility and thus relative immunity from normal democratic process." *Pannell v. City of San Jose* (1988) 485 U.S. 1, 22 (Scalia, J., concurring in part and dissenting in part). Indeed this tentative shift in cost from the State to local government was only possible due to the appointment of an unchecked federal receiver focused on a single purpose—opening a prison hospital—without regard for the chaos created in his wake.

Federal court intervention in California's prison medical program inherently intertwined a Federal court into state and local land use and CEQA regulations that have been characterized as "a complex, time-consuming undertaking" by federal courts (*Tahoe-Sierra Preservation Council, Inc. v. Tahoe Regional Planning Agency* (9th Cir. 2000) 216 F.3d 764, 777) and "complicated...(with l)egal questions resist(ing) easy resolutions" by state courts. *County of Amador v. El Dorado County Water Agency* (1999) 76 Cal.App.4th 931, 939. As this example vividly illustrates, federal activity inherently minimizes or omits legitimate local interests and concerns, interests and concerns normally ventilated, evaluated and mitigated through California's land use process. For instance, an EIR must evaluate the availability of municipal services for a proposal. CEQA Guidelines Cal. Code of Regs. Title 14 Appendix G §XIII. [14]

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[14] One small example may suffice. Without the Chamber's litigation the Receiver would have attempted to compel the City, at the City's expense, to extend water and sewer infrastructure to the prison hospital and then provide these municipal services for free or for a reduced cost with the City's taxpayers making up the shortfall. A theory justifying Stockton taxpayers, but not the taxpayers of California, funding a significant operational cost of a State required facility can only be constructed by using a "wilderness of mirrors". T.S. Elliot, "Gerontion" v. 65.

The Chamber doubts the Federal court anticipated the Receiver's activities would result in this extreme variation from the "normal democratic process" by usurping fundamental State and local affairs. Yet whenever a Receiver decides to build new prison facilities regulatory powers customarily exercised by state and local government and safeguarded from abuse through complex procedures and public review are then exercised by that Receiver without the necessary procedural and public review safeguards. The Receiver operates without sufficient and customary checks and balances. This, to a great extent, is the crux of the problem. The Judicial Panel transferred to the Receiver countless decisions traditionally made by State and local government. State law integrates the exercise of these decisions into a comprehensive regulatory procedural framework emphasizing openness, public participation and due process safeguards as a buttress against overzealous government officials, government misjudgments and abusive use of the police power. Unfortunately, a federal receiver is granted the power to make these decisions, but may dispense with democratically derived procedural safeguards. Consequently, appointing a federal receiver to operate all or part of a State prison system should happen only when the most extreme and extraordinary facts are present. This is why it is critical for the quality of our collective democratic experience that the remedy provided by the Prison Litigation Reform Act be used sparingly and carefully.

III. CONCLUSION

"The Framers of the Federal Constitution [ ] viewed the principle of separation of powers as the absolutely central guarantee of a just Government." *Morrison v. Olson*, 487 U.S. 654, 697 (1988) (Scalia, J., dissenting). For the foregoing reasons, this Court should protect local communities by invalidating the federal intervention into the California Prison System under the decisions in *Plata* and *Coleman*.

Respectfully Submitted,

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AMICUS
CURIAE
BRIEF

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Supreme Court of the United States

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GOVERNOR ARNOLD SCHWARZENEGGER,
ET AL., APPELLANTS,

v.

MARCIANO PLATA AND RALPH COLEMAN, ET AL.

◆

ON APPEAL FROM THE UNITED STATES DISTRICT COURTS FOR THE NORTHERN DISTRICT OF CALIFORNIA AND FOR THE EASTERN DISTRICT OF CALIFORNIA

◆

MOTION FOR LEAVE TO FILE OUT OF TIME AMICUS CURIAE BRIEF OF J. CLARK KELSO, RECEIVER FOR MEDICAL HEALTHCARE FOR THE CALIFORNIA STATE PRISONS AS AMICUS CURIAE SUPPORTING NEITHER PARTY

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MOTION OF J. CLARK KELSO, RECEIVER FOR MEDICAL HEALTHCARE FOR THE CALIFORNIA STATE PRISONS, FOR LEAVE TO FILE OUT OF TIME A BRIEF AS AMICUS CURIAE SUPPORTING NEITHER PARTY

J. Clark Kelso, Receiver for Medical Healthcare for the California state prisons, respectfully moves this Court for leave to file the accompanying brief, as amicus curiae in support of neither party. Under Supreme Court Rule 37.3(a), the deadline to file amicus briefs in support of neither party was September 3, 2010.

Letters from counsel for the parties consenting to the filing of amicus briefs have been filed with the Clerk of this Court pursuant to Supreme Court Rule 37.3(a). In addition, counsel for Appellants Governor Schwarzenegger, et al. ("the State"), Intervenors California State Republican Legislators, et al. ("the Intervenors"), and Appellees do not oppose this motion for leave to file out of time an amicus brief on behalf of the Receiver in support of neither party. Thus, no party opposes the filing of this amicus brief out of time.

On August 27, 2010, the State and the Intervenors filed their opening briefs in this Court. Those briefs rely on statements made by amicus and purport to draw conclusions from those statements. They do not, however, provide a proper context for the statements.

Before the filing of these briefs, amicus had no knowledge that the State and the Intervenors intended to rely on his statements. Accordingly, amicus did not have sufficient time in which to prepare and file a brief in support of neither party, pursuant to Supreme Court Rule 37.3(a), within 7 days of the filing of Appellants' brief.

Amicus seeks to provide this Court with the proper context and explanation of the statements he made on which the parties rely. This context will better enable this Court to properly resolve the case. Moreover, no party will be prejudiced by amicus' filing. This brief is being filed on the due date for amicus briefs supporting Appellees. The State and the Intervenors, who do not object to the late-filing of this brief, will be able to reply to amicus' brief in their reply briefs. Appellees, the only parties that will be unable to respond to amicus' brief, have consented to the late-filing of this specific brief.

Accordingly, amicus respectfully requests leave to file out of time the accompanying brief in support of neither party.

Respectfully submitted,

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INTEREST OF AMICUS CURIAE[1]

Amicus J. Clark Kelso ("the Receiver") is the Receiver for delivery of medical health care services to prisoners confined by the California Department of Corrections ("CDCR"), having been appointed to that position by the district court in *Plata v. Schwarzenegger*, No. C01-1351-TEH (N.D. Cal.) on January 23, 2008. (N.D. Cal. Dkt. #1063), Order Appointing New Receiver.[2] Mr. Kelso succeeded Receiver Robert Sillen, who was appointed by the court on February 14, 2006, to serve effective April 17, 2006. *Id*. at 1.

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[1] Pursuant to Rule 37.3(a), the parties have consented to the filing of amicus briefs. Copies of letters consenting to the filing of briefs by the parties have been filed with the Clerk of the Court. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than amicus curiae, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

[2] Biographical information regarding Mr. Kelso is appended to the district court's order appointing him. *Id*. at 7. As there noted, Mr. Kelso is a Professor of Law and former Director of the Capital Center for Government Law and Policy at the University of the Pacific McGeorge School of Law in Sacramento, California. *Id*. As further noted by the court, Mr. Kelso came "to the California Prison Health Care Receivership with over fifteen years of experience in a wide variety of positions in all three branches of state government," including work with the California Judicial Council and Administrative Office of the Courts, service as interim Insurance Commissioner for the California Department of Insurance, and Chief Information Officer for the State of California. *Id*.

In filing this amicus brief, the Receiver takes no position on the merits of this appeal or the three-judge district court's Order to Reduce Prison Population. The Receiver files this brief solely to provide the Court with the relevant context for statements that he has made that have been quoted by the parties in their briefs to the Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

Appellants Governor Schwarzenegger, et al. ("the State") and Intervenors California State Republican Legislators, et al. ("the Intervenors") argue in their briefs to this Court that certain statements by the Receiver support the conclusion that overcrowding is not a primary cause of the unconstitutional health-care conditions in California's prisons. They rely on statements the Receiver made (1) at a Sacramento Press Club luncheon in 2008 with respect to an $8 billion proposal to improve and expand prison health-care facilities and reduce overcrowding (a plan which the State ultimately rejected as infeasible and too costly in light of declining State revenues), and (2) in a letter to legislators in 2010 where the Receiver was seeking support for the State's significantly-reduced construction plan.

That reliance is misplaced. The Receiver's views regarding the relationship between overcrowding and the provision of constitutional healthcare are best understood by reference to his official reports to the *Plata* district court, which have addressed that issue on a number of occasions. Statements made by the Receiver at a luncheon speech and in letters seeking legislative support for construction funding, when removed by the State and Intervenors from their real-world context, are easily misinterpreted. The Receiver's 2008 Sacramento Press Club statement was made in the context of a proposed $8 billion plan to address overcrowding and healthcare facilities' inadequacies within California's prisons. The State refused to fund that plan as infeasible and unaffordable, and it is no longer under consideration. The Receiver's 2010 statements in support of the State's significantly reduced construction plan do not support a conclusion that this planned construction, if it ever happens, would be sufficient, by itself and in the absence of the population reduction ordered by the three-judge court, to bring about sustainable constitutional healthcare. The Receiver said only that the construction would be a significant step forward, not that the construction would, by itself, be sufficient.

The State and Intervenors would have this Court believe that the Receiver thinks construction is a viable alternative to a population reduction order. That simply is not the case. The $8 billion plan discussed in 2008 was, by the State's own reckoning, infeasible and unaffordable, and the Receiver has never said current construction plans would be sufficient absent a reduction in prison overcrowding.

ARGUMENT

THE RECEIVER'S OFFICIAL STATEMENTS IN COURT-ORDERED REPORTS ARE THE BEST SOURCE FOR THE RECEIVER'S VIEWS ON THE IMPACT OF OVERCROWDING ON THE DELIVERY OF CONSTITUTIONAL HEALTHCARE.

In their opening briefs, the State and the Intervenors repeatedly quote and rely on the Receiver's statement in answer to a question at the Sacramento Press Club on August 13, 2008, that "'we believe we can provide constitutional levels of care *no matter what the population is*.'" State's Br. 17 (emphasis added by the State); *see also id.* at 34 ("the Receiver concluded that the State could 'provide constitutional levels of care *no matter what the population is*' once his plan was fully implemented"); *id.* at 11 (three-judge court found that overcrowding was primary cause of Eighth Amendment violations "despite the Receiver's statements that the State could 'provide constitutional levels of care *no matter what the population is*.'"); *id.* at 39 (Receiver has "acknowledged that full implementation of the Receiver's plans *alone* will be sufficient to ensure Eighth Amendment care."); *id.* at 3 ("The court ordered this massive release despite, *inter alia*, the Receiver's confirmation that care satisfying the Eighth Amendment can be provided notwithstanding prison overcrowding * * * "); Intervenor's Br. 5 ("The Receiver stated, approximately a month before the trial began, 'I'm just not seeing difficulty in providing medical services no matter what the population is.'"); *id.* at 10 ("The *Plata* Receiver stated that, under his control, the California prison systems [sic] would not have any 'difficulty providing medical services (to the entire prison population) no matter what the population is.'").

The Receiver's official reports to the district court are a better representation of his views on the relationship between overcrowding and the provision of constitutional healthcare than (1) a single answer to a question at the Sacramento Press Club two years ago in the context of a proposed $8 billion construction plan that has long since been rejected by the State and abandoned by the Receiver as infeasible and unaffordable, and (2) statements made in letters to legislators seeking support for a significantly reduced construction plan.

For example, the Receiver's most recent filing in the district court concludes that "there are too many prisoners for the healthcare infrastructure." (N.D. Cal. Dkt. #2317), Fifteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, September 29, 2010 at 7. That is the most recent of many reports, which have repeatedly emphasized the central role that overcrowding plays in preventing the delivery of adequate healthcare. *See, e.g.*, (N.D. Cal. Dkt. #524), Receiver's First Bi-Monthly Report, July 5, 2006 at 3 (characterizing "System Long Term Overcrowding" as a "very serious impediment" rendering "the Receiver's assignment difficult, if not impossible, to complete"); (N.D. Cal. Dkt. #547), Receiver's Second Bi-Monthly Report, September 19, 2006, at 2 (noting that "severe overcrowding" is the "root cause" of "constitutionally inadequate medical care"); (N.D. Cal. Dkt. #673), Receiver's Report re Overcrowding, filed May 15, 2007; (N.D. Cal. Dkt. #705), Receiver's Supplemental Report re Overcrowding, filed June 11, 2007; (N.D. Cal. Dkt. #705), Tenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, January 20, 2009, at 2 (discussing overcrowding);

(N.D. Cal. Dkt. #2011), Thirteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, January 15, 2010 at 6 ("CDCR's prisons remain significantly overcrowded, and the lack of adequate facility space and appropriate beds for medical and mental health purposes continues to impede efforts to improve care."); (N.D. Cal. Dkt. #2289), Fourteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, May 27, 2010 at 6, 54 ("Construction and population reduction remain of critical importance to our efforts since the continuing overcrowding that exists within CDCR's adult institutions stands as a significant obstacle to the delivery of care."); (N.D. Cal. Dkt. #2317), Fifteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, September 29, 2010 at 59 ("[T]he Office of the Inspector General in his 'Summary and Analysis of the First 17 Medical Inspections of California Prisons,' suggests that, notwithstanding our efforts, overcrowding remains an obstacle to delivering healthcare to the inmate population.").

In addition, the statements referenced in the State's and Intervenors' briefs have been taken out of context and misinterpreted. When read in context, none of these statements about the importance of healthcare-related construction supports the conclusion that construction alone can result in constitutional healthcare absent a reduction in population.

In 2008, the Receiver and the State discussed the possibility of funding an $8 billion plan to reduce overcrowding and construct and improve healthcare facilities within California's prisons. In a question and answer period at a 2008 Sacramento Press Club luncheon, a participant posed a compound question to the Receiver, which asked about physician recruitment and its relation to prison overcrowding:

> It's been suggested pretty strongly by a lot of people in this arena that the reason that the prison system can't deliver constitutionally adequate healthcare is because of the huge growth in the prison population and that it's not just a matter of beds and facilities, but also being able to deliver services. Like I understand in a lot of rural counties it's very hard to get doctors and clinical personnel. And I'm just wondering if you, as the Receiver, do you have an official position on what we should do about the prison population?

(N.D. Cal. Dkt. #1656, Ex. D (DVD)), Statement of J. Clark Kelso, Aug. 13, 2008, at 28:26-29:00.

The Receiver first addressed the recruitment issue, commenting that: "We're not having that much difficulty in recruiting clinical personnel anywhere in the state. It turns out when you raise compensation to private sector levels, people will come." *Id.* at 29:09-29:23. He went on to discuss the challenges of recruiting in the desert portion of the state versus the state's coastal areas, where "the expenses of living * * * are a little higher," and concluded his discussion of the recruitment issue by stating:

> So I'm just not seeing difficulty in providing medical services no matter what the population is. It's a question of how much you are willing to spend for it.

Id. at 30:01-30:17.

The Receiver then turned to the overcrowding part of the question and answered in full as follows:

> Now, the overcrowding, without doubt, overcrowding creates additional, not just expenses, but complications in providing medical services because, frankly, everything in the prisons is made more difficult by overcrowding. They can't provide any sort of program, for example, in many prisons. They just don't have room to provide any sort of programs, so everybody is sitting around. Well that by itself creates healthcare problems.
>
> If you ever walked up and down the gymnasiums where they are bunked three high, I have absolutely no doubt that the conditions of overcrowding by itself contributes to greater morbidity. It's like birds on a wire who are crammed too close together. It creates additional stress. I'm confident that's happening. Is it happening to any huge and great extent that we can't respond to? I'm less sure about that. I think we've discovered that you actually can provide care and certainly *our Plan and Turnaround Plan*, believe we can provide constitutional levels of care no matter what the population is.

Id. at 30:19-31:28 (emphasis added).

The Receiver's reference to the "Plan and Turnaround Plan" was to the Receiver's then-current plan, which included a proposal to reduce overcrowding and expand and improve prison healthcare facilities at a capital cost of $8 billion (which did not include the ongoing costs of operating the new facilities).

The Legislature rejected the $8 billion plan in late 2008, the State withdrew its support for that plan, and the Receiver has abandoned the $8 billion proposal as infeasible and unaffordable. Thus, the Receiver's 2008 remarks at the Sacramento Press Club are irrelevant today, since they were premised upon a plan that the State and Receiver have abandoned as infeasible and unaffordable.

The State and the Intervenors also rely on statements made by the Receiver in 2009 and 2010 with regard to the State's significantly revised and reduced construction plan, which calls for $2.35 billion in healthcare related construction. The State notes that the Receiver referred (in a newsletter) to the State's submission to the *Coleman* court of its revised plan as "'an extraordinary milestone.'" State's Br. 37. The Intervenors quote a May 17, 2010 letter from the Receiver to an assembly member, written as part of the effort to obtain legislative funding for the new plan, which stated that "[a]pproval of AB 552 in order to fund our negotiated construction plan will represent a significant step towards conclusion of the Federal Receivership." Intervenors' Br. 11 n.8.

These statements were true when made and remain true today. By any measure, $2.35 billion in funding to expand and improve healthcare facilities at existing prisons is a significant step forward, assuming the construction actually happens.[3] Given the desperate need of the California prison healthcare system for additional facilities and overcrowding reduction, it is certainly better than *no construction* at all. However, the assessment reflected in these statements is in no way equivalent to a conclusion that the current compromise on construction will result in sustainable constitutional healthcare at current population density levels.

Finally, the State also quotes the Receiver as stating that "because '[p]atient-inmate access to health care has markedly improved,' 'we are projecting that control of the Health Care Access Units *can be transferred back to CDCR* as early as next year, with a target for July 2011.'" State's Br. 19. This statement reflects the fact that one small element of the Receiver's plan involving the use of custody officers to facilitate inmate access to care for previously scheduled appointments appears to have been successful. Success on that one small element does not guarantee that all other elements of the plan will be equally successful at current population density levels. Indeed, as noted in the Receiver's most recent report to the *Plata* court:

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[3] Implementation of the construction plan is dependent upon approvals yet to be secured from a legislative committee and from several state boards. That such approvals may ultimately not be forthcoming is apparent from the most recent denial by the Joint Legislative Budget Committee of one part of the plan involving construction of mental health and medical beds at a prison facility located in Chico, California. (N.D. Cal. (No. 90-cv-00520-LKK-JFM) Dkt. #3941), Defendants' Update to Court re: Construction and Funding of Defendants' Amended Stark Plan, October 19, 2010 at 6.

> [o]vercrowding also is a primary factor causing the comparatively low [Office of Inspector General] score in the Access to Providers and Services category, which essentially focuses upon the timeliness of care pursuant to CDCR policies * * * our Health Care Access teams continue to be highly effective in facilitating inmate access to scheduled appointments. However, the sheer number of inmates at each facility frustrates our effort to meet the required timelines for access to physicians and specialty providers * * * . [T]he OIG scores highlight the overriding challenge of trying to provide medical care in the context of a highly overcrowded prison system where there are too many prisoners for the healthcare infrastructure, and there is a high incidence of overcrowding-related violence resulting in lockdowns and modified programs that interfere with the efficacy of the medical system.

(N.D. Cal. Dkt. #2317), Fifteenth Tri-Annual Report of the Federal Receiver's Turnaround Plan of Action, September 29, 2010 at 6-7.

CONCLUSION

The Receiver does not intend by filing this brief to take any position on the merits of the legal issues before the Court. He does seek to give the Court the proper context to understand statements attributed to him in the briefs submitted by the State and the Intervenors. As demonstrated above, those statements do not express a belief that the State's and Receiver's current efforts will result in constitutional healthcare at existing population density levels.

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Appellees.

On appeal from the United States District Courts for the Eastern District and Northern District of California

BRIEF FOR THE STATES OF LOUISIANA, ALABAMA, ALASKA, ARKANSAS, COLORADO, DELAWARE, ILLINOIS, MASSACHUSETTS, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, TEXAS, AND VIRGINIA AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS

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QUESTIONS PRESENTED

The appellants have presented three questions concerning the lower court's application of the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626. Amici curiae's argument relates to the second two:

2. Whether the court below properly interpreted and applied Section 3626(a)(3)(E), which requires a three-judge court to find, by clear and convincing evidence, that "crowding is the primary cause of the violation of a Federal right; and ... no other relief will remedy the violation of the Federal right" in order to issue a "prisoner release order."

3. Whether the three-judge court's "prisoner release order," which was entered to address the allegedly unconstitutional delivery of medical and mental health care to two classes of California inmates, but mandates a system-wide population cap within two years that will require a population reduction of approximately 46,000 inmates, satisfies the PLRA's nexus and narrow tailoring requirements while giving sufficient weight to potential adverse effects on public safety and the State's operation of its criminal justice system.

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INTEREST OF AMICI CURIAE

This appeal concerns the propriety of a three-judge court's application of the PLRA when imposing a population cap on California's correctional system that would require the release of approximately 46,000 state prisoners.[1] Amici curiae, like any other states, may someday be forced to defend against lawsuits filed under the PLRA with the aim of forcing large-scale prisoner releases. Consequently, amici have a substantial interest in the disposition of this case, and present this brief in support of appellants, Arnold Schwarzenegger, Governor of California, *et al.*, pursuant to Supreme Court Rule 37.4.

SUMMARY OF ARGUMENT

The three-judge court has violated the plain language of the PLRA, and needlessly threatened public safety, by ordering the release of tens of thousands of prisoners without determining whether there were any ongoing federal constitutional violations in the state's prison system.

Under the PLRA, a court may not issue a prisoner-release order unless the prisoners prove by clear and convincing evidence that such relief is necessary to remedy an ongoing violation of their federal rights, and that no narrower remedy is possible. Thus, the starting point when considering a request for a prisoner-release order must always be the issue of whether there are in fact ongoing violations, and if so what is the nature and scope of the current violations. Until that question is answered, a court cannot determine whether any new relief is warranted, much less what the narrowest possible relief would be.

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[1] *See Coleman v. Schwarzenegger*, 2009 WL 2430820, *106, 2009 U.S. Dist. LEXIS 67943, *136 (E.D. Cal. Aug. 4, 2009) ("Under the order establishing a population cap, the size of the prison population will be reduced by approximately 46,000").

Nevertheless, the three-judge court not only refused to consider whether there were ongoing federal violations in the state's prison system, it prohibited the state from presenting evidence on the issue. Instead, the three-judge court relied on the fact that individual district courts had found violations years before, when issuing much less onerous prospective relief, and that the state had not sought to terminate that lesser relief. But those prior findings did not speak to the presence of ongoing violations at the time of the three-judge court's decision, and, in any event, were made under a lower standard of proof than is required for a prisoner-release order. Moreover, the state had no statutory burden to terminate the earlier relief; rather, the burden of proof remained with the prisoners to prove current and ongoing violations that could only be remedied with a prisoner-release order. Thus, the individual district courts' prior orders did not resolve the issue before the three-judge court.

While that error would itself be sufficient to warrant reversal, it is noteworthy that the three-judge court's own opinion offers good reason to question whether, and, if so, to what extent there are ongoing constitutional violations in the state's correctional system. The underlying claims in these cases are that the state's treatment of the prisoners' serious medical and mental health problems is so deficient as to constitute cruel and unusual punishment, in violation of the Eighth Amendment. But the three-judge court's analysis was incompatible with the demanding standards governing such claims. Time and again, the court substituted expert opinion for constitutional minima, prior deficiencies for current conditions, and idealized practices for those demanded by contemporary standards of decency.

In addition, it follows that the three-judge court violated the PLRA's requirements that a prisoner-release order be the only possible remedy, and that it be narrowly drawn. In the first place, systemwide relief would have required ongoing, systemic violations, which, again, were not found. But even putting that aside, there would have been no justification for the scope of the three-judge court's order, which impermissibly would require the release of a great number of prisoners who have no serious medical or mental health needs, and are not even class members in the underlying lawsuits.

Finally, real-world experience with large-scale prisoner-release orders undermines the three-judge court's remarkable prediction that releasing tens of thousands of prisoners will not affect, or will even *enhance*, public safety. Prior experience shows that, even when targeted at the prisoners who are supposed to represent the best of the worst, such orders inevitably place innocent citizens at much greater risk of victimization.

ARGUMENT

I. The three-judge court violated the PLRA by issuing a prisoner-release order without finding an ongoing violation of a federal right.

At their essence, the issues before the Court are neither complex nor fact-bound. Under the plain language of the PLRA, the alleged violation of a federal right is what guides every step. It is the violation that makes state prison conditions a proper subject for federal review, renders prospective relief necessary, and limits the permissible extent of that relief. In particular, the PLRA expressly and repeatedly requires that any prospective relief, especially the last-resort remedy of a prisoner-release order, be narrowly tailored to correct a violation of a federal right of a specific prisoner or class of prisoners. *See* 18 U.S.C. § 3626(a)(1)(A), (a)(1)(B), (a)(3)(E).

It is thus necessary that, before ordering prospective relief, a court find an ongoing federal violation, and define the nature and scope of that current violation with reasonable specificity. Absent a specific, ongoing violation, it would be meaningless to claim that a particular form of relief is necessary and narrowly-tailored.

Nevertheless, the three-judge court refused to follow the statutorily-required procedure, erroneously declaring that it "need not ... again evaluate the state's continuing constitutional violations" when issuing prospective relief in the form of a large-scale prisoner-releaser order. *Coleman*, 2009 WL 2430820, *31, 2009 U.S. Dist. LEXIS 67943, *136. Indeed, the three-judge court went so far as to prohibit "the introduction of evidence relevant only to determining whether the constitutional violations ... were 'current and ongoing.'" *Id.*, 2009 WL 2430820, *31 n.42, 2009 U.S. Dist. LEXIS 67943, *137 n.42. That approach was irreconcilable with the terms and structure of the PLRA, and has resulted in an unjustified prisoner-release order that threatens public safety.

A. The failure to determine whether the alleged violations were ongoing cannot be reconciled with the language and structure of the statute.

The first and most basic requirement of the PLRA is that any prospective relief, *i.e.*, any relief other than compensatory monetary damages, 18 U.S.C. § 3626(g)(7), "shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." 18 U.S.C. § 3626(a)(1)(A). Whenever a court orders prospective relief pursuant to the PLRA, it must find "that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." *Id.*

Thus, the starting point when considering prospective relief must always be a violation of particular prisoners' federal rights. Moreover, that violation must be current and ongoing at the time the relief is granted.[2] Otherwise, the requirement that the prospective relief "extend[ ] no further than necessary to correct the violation" would be nonsensical, and the consistent use of the present tense when referring to the violation would be stripped of its ordinary significance. *See Carr v. United States*, ___ U.S. ___, 130 S.Ct. 2229, 2230-31 (2010) ("[T]he present tense generally does not include the past...."), *citing* 1 U.S.C. § 1.

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[2] Although the phrase "current and ongoing" is used elsewhere in the PLRA, in reference to petitions to terminate prospective relief, 18 U.S.C. § 3626(b)(3), amici use it in this (continued...

In addition, the PLRA imposes special requirements for prospective relief, such as the relief at issue here, that "requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law." 18 U.S.C. § 3626(a)(1)(B).[3] In this context, a court may not order prospective relief unless "(i) Federal law requires such relief to be ordered in violation of State or local law; (ii) the relief is necessary to correct the violation of a

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context only because it was the three-judge court's formulation; any word or phrase that conveys the need for present violations would serve equally well.

[3] According to the population reduction plan submitted by the state and approved by the three-judge court, many of the measures necessary to comply with the court's prisoner-release order, such as reducing the grading of certain offenses and moving inmates to private or out-of-state facilities, violate state law. J.S. App. 59a-69a. And of course, those are hardly the only respects in which the prisoner-release order intrudes in areas typically reserved to the states Every time a state inmate is released earlier than he would have been but for a federal court's population cap, or is not admitted in the first place because of such a cap, the state's basic prerogative to establish and enforce its own criminal laws is restricted.

Federal right; and (iii) no other relief will correct the violation of the Federal right." *Id.*

While these requirements for relief that contravenes state law are similar to the general standards for all prospective relief, they are more than "absentminded duplication." *Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990); *see also Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 837 & n. 11 (1988). Rather, they mean precisely what they say: prospective relief that contravenes state law must be required by the pertinent federal right itself, and it must be the *only* possible means of correcting the violation of that right.

Finally, the PLRA imposes yet another set of requirements when, as is also the case here, the prospective relief is a prisoner-release order. Such orders may only be issued by a three-judge court upon a "find[ing] by clear and convincing evidence that ... crowding is the primary cause of the violation of a Federal right; and ... no other relief will remedy the violation of the Federal right." 18 U.S.C. § 3626(a)(3)(E).

These requirements impose a new and higher standard of proof ("clear and convincing evidence"), and therefore cannot be satisfied by the individual district court's prior findings, which would have been made under a lower standard. Moreover, like the earlier provisions, they are phrased in the present tense, and applying them could only make sense if there were a current and ongoing violation to correct. Thus, they, too, require a court considering a prisoner-release order to first find, based on a complete record, that there is an ongoing federal violation that cannot be remedied through any lesser measures.

Given these statutory requirements, the three-judge court's decision violated the plain language and structure of the PLRA, and undermined its manifest purpose of making prisoner-release orders a remedy of absolute last resort. Since the three-judge court did not determine whether the alleged constitutional violations were still ongoing, there was no basis for it to issue *any* new remedy. And since the three-judge court did not determine whether the alleged constitutional violations were extraordinary in their current form, there particularly was no basis for it to issue a remedy so unprecedented in scope that it would require the release of approximately 46,000 prisoners.

B. The proffered explanations for the three-judge court's approach have no merit.

The three-judge court and the prisoners have offered several arguments in support of their position that it was unnecessary for the court to determine whether and, if so, to what extent the alleged constitutional violations were ongoing. As set forth below, those arguments have no statutory or logical basis.

1. The three-judge court erred by relying on the individual district courts' prior findings of constitutional violations.

The three-judge court's primary explanation for its refusal to determine whether the alleged constitutional violations were ongoing was that --

years before the prisoner-release order -- the individual district courts had found that there were then ongoing constitutional violations. *Coleman*, 2009 WL 2430820, *30-31, 2009 U.S. Dist. LEXIS 67943, *136-37.[4] Reliance on those prior decisions was error.

At the outset, while the procedural histories of these cases are lengthy, it is important to remember that *Plata* had its genesis in a stipulated remedial order that did not address whether state officials had acted with deliberate indifference, as would have been required to establish a violation of the Eighth Amendment. *See* Stipulation for Injunctive Relief, filed Jun. 13, 2002. This was not unusual, as such orders sometimes "go well beyond what is required by federal law." *Horne v. Flores*, ___ U.S. ___, 129 S.Ct. 2579, 2594 (2009).[5] Yet as a predictable consequence, while the individual district court stated as a general matter that unconstitutional conditions in the state's correctional system had not been corrected as of 2005, it did not distinguish between conditions that were a result of the deliberate indifference required for a constitutional violation, and conditions that were merely contrary to the stipulated order. *See Plata v. Schwarzenegger*, *supra*, 2005 WL 2932253, 2005 U.S. Dist. LEXIS 43796.

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[4] Interestingly, the individual district court in *Plata* also found that the primary cause of the alleged failure to provide constitutionally-adequate care was not overcrowding, but poor management, leading to ill-considered staffing and record-keeping practices. *See Plata v. Schwarzenegger*, 2005 WL 2932253, *29, 2005 U.S. Dist. LEXIS 43796, *83 (N.D. Cal. Oct. 3, 2005) ("[T]he single root cause of this crisis[ ] [is] an historical lack of leadership, planning, and vision by the State's highest officials during a period of exponential growth of the prison population," manifesting itself in a failure to take measures "such as taking incompetent doctors out of patient care, hiring qualified new doctors and nurses, and providing a medical records system....").

[5] For an explanation of why public officials may enter such agreements, even when they are not constitutionally required, see Gerald N. Rosenberg, "The Politics of Consent. Party Incentives in Institutional Reform in Consent Decrees," in *Consent and Its Discontents: Policy Issues in Consent Decrees*, (continued. .

But even putting that aside, the individual district courts in *Plata* and *Coleman* did not purport to make their findings of constitutional violations under a "clear and convincing" standard of proof, nor was there any reason for them to do so. The PLRA imposes that standard only for prisoner-release orders, 18 U.S.C. § 3626(a)(3)(E), and thus requires the three-judge court to make an independent finding before issuing such relief.

Finally, even if there had been clear and convincing evidence of "ongoing" constitutional violations when the cases were before the individual district courts years earlier, it would not follow that there also must have been ongoing violations when the three-judge court issued its decision in August 2009, much less when it issued its final order in January 2010. A correctional system can change a great deal over a period of years. The three-judge court itself recognized as much when issuing its prisoner-release order, which would be implemented over the course of two

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13-38 (2006), *available at* http://www.princeton.edu/prior/publicatons/docs/consent.pdf.

years. And, more importantly, the terms and structure of the PLRA recognize such realities with their consistent requirement of ongoing violations. Thus, contrary to the three-judge court's view, the issue of whether the alleged constitutional violations were "current and ongoing" could not be divorced from the question of whether the drastic remedy of a large-scale prisoner-release order was necessary.

Even under traditional limitations on prospective injunctive relief, the three-judge court's failure to tailor its prisoner-release order to a current and ongoing constitutional violation would have been error. *See Imprisoned Citizens Union v. Ridge*, 169 F.3d 178, 188 (3d Cir. 1999) (Alito, J.) ("[C]onsistent with well-established limitations on the courts' authority to issue prospective injunctive relief to remedy constitutional violations..., the remedy imposed must be tailored -- temporally as well as substantively -- to redress the constitutional wrong at issue"), and cases cited therein. *See also O'Shea v. Littleton*, 414 U.S. 488, 493 (1974) (absent ongoing constitutional harm, "[p]ast exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief...."). *A fortiori*, that failure was error under the PLRA's requirements for prospective relief, which are at least as demanding.

2. *The denial of the state's summary judgment motion did not resolve the question of whether there were ongoing constitutional violations.*

The three-judge court offered a *non sequitur* when it claimed in the alternative that, "even if [it] were required to find independently that the requirements of § 3626(a)(3)(A) -- including its requirement that prior orders have 'failed to remedy the deprivation of the Federal right' -- have been met, [it] did so in denying defendants' motion for summary judgment." *Coleman*, 2009 WL 2430820, *31, 2009 U.S. Dist. LEXIS 67943, *137. In the first place, it was simply incorrect to claim that the order denying the state's motion for summary judgment included a finding of ongoing constitutional violations. *See Coleman v. Schwarzenegger*, 2008 WL 4813371, *4 (E.D. Cal. Nov. 3, 2008) (not available on Lexis) (relying on three- and thirteen-year-old findings by individual district courts). But even if the three-judge court had made such a finding for purposes of the motion for summary judgment, it would have done so before any witnesses testified at trial, and under a standard that required the court to view the facts in the light most favorable to the prisoners. *Scott v. Harris*, 550 U.S. 372, 378 (2007). Thus, as would seem elementary, a finding of an ongoing violation at the summary-judgment stage would not have resolved the issue at the subsequent trial.

3. *It was the prisoners' burden to prove ongoing violations warranting new and greater relief, not the state's burden to terminate earlier relief.*

The three-judge court's failure to determine whether there were ongoing constitutional violations also was not excused by its observation that the state had not moved to terminate other, less onerous prospective relief, which had been entered years before by the individual district courts. *Coleman*, 2009 WL 2430820, *31, 2009 U.S.

Dist. LEXIS 67943, *137. At the outset, this observation again ignored the fact that two years had passed since the cases were before the individual district courts, and thus that the earlier proceedings did not necessarily reflect current conditions.

Moreover, under circuit precedent, if the state had moved to terminate the earlier prospective relief, it would have had the burden to prove the absence of an ongoing violation. The Ninth Circuit stands alone in placing the burden on the state to prove the absence of an ongoing violation when it files a motion to terminate prospective relief. *Compare Gilmore v. Enomoto*, 220 F.3d 987, 1007 (9th Cir. 2000) ("[T]he burden of proof ... [lies with] the party seeking to terminate the prospective relief"), *with Guajardo v. Tex. Dep't of Crim. Justice*, 363 F.3d 392, 395-96 (5th Cir. 2004) (per curiam) (stating, with respect to motions to terminate prospective relief, "We agree with the great majority of courts to address this issue: a plain reading of the PLRA, including its structure, imposes the burden on the prisoners"); *and Laaman v. Warden, N.H. State Prison*, 238 F.3d 14, 20 (1st Cir. 2001) (stating, with respect to petition to terminate prospective relief, "[T]he burden remains on the plaintiffs to show that such violations [of their federal rights] persist"). Nevertheless, circuit precedent would have bound the district courts had the state sought to terminate the earlier prospective relief.

In contrast, for new prospective relief, particularly a prisoner-release order, the PLRA places the burden of proof on the prisoners, who must establish by clear and convincing evidence, *inter alia*, that there is an ongoing violation, and that previous remedial attempts have failed to correct it. 18 U.S.C. § 3626(a)(3)(E). Thus, by relying on the fact that the state had not sought to terminate the earlier prospective relief, the three-judge court misallocated the burden of proof, again contravening the plain language of the statute.

4. The three-judge court prohibited the state from presenting evidence on whether there were ongoing constitutional violations, but even if it had, the court's failure to determine whether there were such violations would have been error.

The *Coleman* appellees suggested at the jurisdictional stage that, because the district court heard testimony from certain experts who had recently toured the prisons, the three-judge court did not erroneously prohibit the state from presenting evidence on whether the alleged constitutional violations were current and ongoing. *Coleman* Mot. to Dismiss, 30-31. That claim was simply incorrect, but, regardless, it could not remedy the three-judge court's principal error, which was much deeper than a simple evidentiary misstep. Again, the three-judge court's basic error was in failing to determine (even on the evidence before it) whether and, if so, to what extent the alleged constitutional violations were ongoing.

The prisoners' suggestion that the three-judge court did not prohibit evidence on the question of whether the alleged constitutional violations were "current and ongoing" would surely come as a surprise to the three-judge court. Prior to trial, the state argued that the issue of whether the alleged constitutional violations were ongoing was central, and requested permission to present evidence on the point, but the three-judge court denied that request. Pretrial Tr. 28:16-29:2. Thereafter, the state sought reconsideration, arguing that the three-judge court's preclusion of evidence on that issue was irreconcilable with the terms of the PLRA, but the court denied that request as well, again ruling that evidence of whether there were ongoing constitutional violations would not be admitted. Trial Tr. 6:24-7:9. *See also id.* at 57:11-58:13.[6] In addition, as explained above, the three-judge court expressly acknowledged in its opinion that it did not permit evidence relevant only to the question of whether the alleged constitutional violations were still ongoing. *Coleman*, 2009 WL 2430820, *31 n.42, 2009 U.S. Dist. LEXIS 67943, *137 n.42.

But in any event, even if the three-judge court had permitted the state to present evidence on the question of whether the alleged constitutional violations were ongoing, that would not have excused the court's failure to make a determination on the issue, and to hold the prisoners to their statutory burden of proof when doing so. Again, the PLRA does not require the state to prove a negative, *i.e.*, the absence of any constitutional violations in its entire correctional system. Rather, it requires the prisoners to prove by clear and convincing evidence -- and the three-judge court to find -- that crowding is the primary cause of such violations, and that no remedy short of a prisoner release order could possibly correct the violations. 18 U.S.C. § 3626(a)(3)(E). Obviously, one cannot determine the "cause" of a violation without knowing whether the violation exists in the first place, and cannot create the narrowest possible "remedy" for the violation without knowing the scope of the violation. Thus, there can be no meaningful application of those statutory requirements unless the three-judge court determines for itself whether and, if so, to what extent there are ongoing violations.

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[6] Even in the limited portion of the transcript cited by the prisoners in ostensible support of their claim that the state was not precluded from presenting relevant evidence, the three-judge court reiterated that evidence would not be received to the extent that it addressed only "the question of whether or not there's a continuing constitutional violation" because that supposedly was not among the "questions that are properly before the court...." Trial Tr. 837:16-837:24.

C. The three-judge court's own opinion creates serious doubts about whether and, if so, to what extent there were ongoing constitutional violations.

Because the three-judge court contravened the PLRA by issuing relief that was not tethered to any finding of an ongoing violation of the prisoners' federal rights, the three-judge court's judgment would be untenable even if the prisoners' underlying constitutional claims had any current merit. That issue is for the three-judge court in the first instance, and it has yet to address the question. Nevertheless, it is noteworthy that the three-judge court's own opinion creates serious doubts about whether the alleged violations actually were ongoing, and, if so, whether they were so extraordinary in their current form that the only possible remedy was to release tens of thousands of prisoners.

The underlying constitutional claim in this case is that the state's treatment of the prisoners' serious medical and mental health needs is so contrary to minimum standards of decency as to constitute cruel and unusual punishment, in violation of the Eighth Amendment. And, of course, the standard for such claims is demanding.

An inmate alleging that prison officials have engaged in cruel and unusual punishment by failing to provide essential health care cannot obtain relief "simply on the ground that the prison medical facilities [are] inadequate...." *Lewis v. Casey*, 518 U.S. 343, 350 (1996). Rather, he must prove that he has suffered actual harm as a result of the officials' "deliberate indifference to [his] serious illness or injury," *Estelle v. Gamble*, 429 U.S. 97, 105 (1976); or that, because of the officials' deliberate indifference, he is being involuntarily exposed to a health risk that is "'*sure or very likely* to cause serious illness and needless suffering,' and give rise to 'sufficiently *imminent* dangers.'" *Baze v. Rees*, 553 U.S. 35, 50 (2008) (plurality), *quoting Helling v. McKinney*, 509 U.S. 25, 34-35 (1993) (emphasis added by this Court). Similar to criminal recklessness, "deliberate indifference" requires that the prison officials be aware of, and disregard, an "excessive risk to inmate health or safety[.]" *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

When the three-judge court's decision is considered in light of this standard, the most striking aspect of the court's approach is that it relied neither on objective measures of community expectations for prison health care, nor on evidence of deliberate indifference by the state defendants. Instead, at nearly every turn, both when discussing alleged inadequacies in particular facets of the prison health care system, and when blaming overcrowding for those perceived deficiencies, the three-judge court explained its decision by reference to expert opinion testimony from prison administrators. *See, e.g.*, *Coleman*, 2009 WL 2430820, *36, 2009 U.S. Dist. LEXIS 67943, *151-52 (accepting expert testimony that prisoners should not be examined in areas where their privacy is protected only by a fabric screen); 2009 WL 2430820, *36, 2009 U.S. Dist. LEXIS 67943, *153 (accepting expert testimony that prisoners should undergo "a physical exam, as opposed to a medical interview," when they are admitted).

The problem with this approach is that the issue on which the expert witnesses actually opined -- whether the state's correctional system comported with their understanding of professional standards -- is not of constitutional significance. *See Rhodes v. Chapman*, 452 U.S. 337, 348 n.13 (1981) ("[O]pinions of experts as to desirable prison conditions.... 'simply do not establish the constitutional minima; rather, they establish goals recommended by the organization in question'"), *quoting Bell v. Wolfish*, 441 U.S. 520, 543-44 n.27 (1979); *Inmates of Occuquan*, 844 F.2d 828, 837 (D.C. Cir. 1988) ("It is cruel conditions, defined by reference to community norms, to which the Constitution speaks; neither 'deficient' conditions nor conditions that violate 'professional standards' rise to the lofty heights of constitutional significance"). *See also Bobby v. Van Hook*, ___ U.S. ___, 130 S.Ct. 13, 16-17 (2009) (*per curiam*) (reversing judgment that treated professional standards as constitutional minima); *id.* at 20 (Alito, J., concurring) (explaining that it is the responsibility of the courts, not professional organizations, to determine the requirements of the Constitution). Consequently, such heavy reliance on expert opinion not only is unwarranted, it has a corrupting tendency to lead courts away from the discrete Eighth-Amendment questions before them, and toward the larger world of prison administration (and criminal-justice policy), where they do not belong. *See Lewis v. Casey*, 518 U.S. at 350 (distinction between courts and prison officials "would be obliterated" if, despite absence of constitutional harm, courts intervened merely because prisoners were "being subject to a governmental institution that was not organized or managed properly"); *Inmates of Occuquan*, 844 F.2d at 837 ("[T]he obvious danger of employing professional standards as benchmarks is that they ineluctably take the judicial eye off of core constitutional concerns and tend to lead the judiciary into the forbidden domain of prison reform").

Moreover, many of the three-judge court's particular observations and findings were deeply suspect for additional reasons if they were supposed to be components of Eighth Amendment violations (as they would have had to be to support the remedy). For example, the court claimed that, according to expert testimony, "[*a*]*s of mid-2005*, a California inmate was dying needlessly every six or seven days." *Coleman*, 2009 WL 2430820, *1, 2009

U.S. Dist. LEXIS 67943, *39 (emphasis altered). But while that would indeed have been highly troubling if it were true, the constitutional question concerned current conditions, not conditions "as of mid-2005," and current conditions were dramatically better by the three-judge court's chosen measure.

According to the court-appointed receiver, who now includes definitely-preventable deaths in the broader category of "likely" preventable deaths, there were just three likely-preventable deaths in 2007 (one every 121 or 122 days), the last year for which the three-judge court would have had statistics. *See* Jurisdictional Statement, 15.[7] Moreover, the three-judge court did not claim that any of the likely-preventable deaths from 2007 or later were attributable to Eighth Amendment violations. Thus, there is good reason to question whether, and, if so, to what extent, even the three-judge court's most disturbing claim was of ongoing constitutional significance.

The three-judge court also focused on the fact that, because of limited space and personnel, the state often conducted medical interviews, rather than full medical and dental examinations, when admitting new prisoners. According to the three-judge court, "This violates the 'basic principle that incoming prisoners must undergo a comprehensive exam upon arrival so that an adequate treatment plan may be developed and implemented. A physical exam, as opposed to a medical interview, is necessary because some conditions can be identified and confirmed only through physical examination of the patient.'" *Coleman*, 2009 WL 2430820, *36, 2009 U.S. Dist. LEXIS 67943, *153 (citations to record omitted). But whatever the source of this "basic principle," it was not the Eighth Amendment's proscription of cruel and unusual punishments. Treating the failure to comply with such "principles" as components of an Eighth Amendment violation would ignore this Court's holdings that prison officials do not violate their constitutional duties unless they disregard a known risk that is *sure or very likely* to cause *imminent* harm, *Baze v. Rees*, 553 U.S. at 50, and would establish as a constitutional minimum a level of care far beyond even community standards for non-incarcerated individuals. *See, e.g.*, Ateev Mehrotra, M.D., *et al.*, *Preventive Health Examinations and Preventive Gynecological Examinations in the United States*, Archives of Internal Med., Sep. 24, 2007, Vol. 167, at 1876-83 (reporting that only 21% of Americans undergo preventive health exams, and that prominent clinical organizations, including the American College of Physicians, do not recommend such exams for asymptomatic patients).

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[7] In December 2009, after the three-judge court issued its decision, the court-appointed receiver published statistics for 2008, when there were five likely-preventable deaths for the year. *See* Kent Imai, M.D., *Analysis of Year 2008 Death Reviews*, Dec. 14, 2009, at 8, *available at* http://www.cprinc.org/docs/resources/OTRES_DeathReviewAnalysisYear2008_20091214.pdf. Those are the most recent figures available to amici.

Another area that the three-judge court singled out for attention was the supposed lack of medical privacy enjoyed by prisoners. *See Coleman*, 2009 WL 2430820, *39, 2009 U.S. Dist.

LEXIS 67943, *161 (crediting expert testimony that state violated "fundamental medical confidentiality rights" by using only fabric screens to protect privacy); 2009 WL 2430820, *67, 2009 U.S. Dist. LEXIS 67943, *243 (faulting state for allegedly ignoring, *inter alia*, "the need for clinical privacy"). But to state the obvious, privacy rights in prison must often give way to the need for institutional security in prison, *see generally Hudson v. Palmer*, 468 U.S. 517 (1984); any embarrassment that might accompany being overheard speaking with a prison doctor is a far cry from the "wanton infliction of pain" prohibited by the Eighth Amendment, *see, e.g., Farmer v. Brennan*, 511 U.S. at 834; and the mental state involved in using only fabric screens to shield inmate privacy cannot reasonably be characterized as knowing disregard of a risk that is "*sure or very likely*" to lead to "*imminent*" harm. *Baze v. Rees*, 553 U.S. at 50.

Much of the remainder of the three-judge court's opinion focused on a litany of respects in which, according to expert opinion, the state correctional system had insufficient personnel, equipment, and recordkeeping. *See, e.g., Coleman*, 2009 WL 2430820, *43-49, 2009 U.S. Dist. LEXIS 67943, *175-91. But as was typical of the lower court's decision as a whole, those alleged deficiencies were not tied to any current, specifically-identified constitutional violations. And in any event, even if the claimed shortage of manpower and other resources were causing ongoing constitutional violations, the obvious remedy would be to increase their supply by hiring more doctors, custodians, and record-keepers, not to decrease demand by releasing prisoners.

Such examples demonstrate the extraordinary disconnect between the standards of the Eighth Amendment and the PLRA on the one hand, and the approach taken by the three-judge court on the other. While this Court has explained that *some* prison conditions may have a mutually re-enforcing effect for purposes of the Eighth Amendment, *Wilson v. Seiter*, 501 U.S. 294, 304-05 (1991), that was not license for the three-judge court to aggregate *inappropriate* factors by, for example, treating expert opinions as constitutional minima, selectively relying on stale data rather than current conditions, and demanding a standard of care that would be uncommonly high even outside the prison context.

But regardless, as explained at the outset, the three-judge court's fundamental error was in not even *considering* the question of whether and, if so, to what extent there were ongoing constitutional violations. Consequently, there is no need for this Court to decide how that question should have been answered. Amici raise the underlying Eighth Amendment issue only to illustrate one of the chief dangers of the three-judge court's procedural error -- that it may well be cloaking an even bigger substantive error.

II. The remedy of releasing thousands of prisoners whose constitutional rights have not been violated was not necessary and narrowly drawn.

As is implicit in the foregoing discussion, the three-judge court's order requiring the release of approximately 46,000 prisoners -- many of whom likely have no serious medical or mental health needs, and thus are not class members in the underlying lawsuits -- also violates the PLRA's requirements that prisoner-release orders may not be issued unless "no other relief will remedy the violation of the Federal right," 18 U.S.C. § 3626(a)(3)(E)(ii); and that, when issued, they must be "narrowly drawn, [and] extend[ ] no further than necessary to correct the violation of the Federal right…." 18 U.S.C. § 3626(a)(1)(A).

At the outset, this Court has made clear that any systemwide remedy, even one far short of a mass prisoner-release, is "patently" inappropriate when only a few isolated constitutional violations are established. *Lewis v. Casey*, 518 U.S. at 359-60. *See also Rizzo v. Goode*, 423 U.S. 362, 373 (1976) (twenty violations insufficient to justify sweeping equitable relief affecting 7,500 local officers). All the more so, such a remedy was grossly inappropriate here, as there were no findings of *any* ongoing constitutional violations.[8]

Moreover, even if there were current violations, the challenged relief would be overbroad in that it would force the release of prisoners who have no serious medical or mental health needs, and consequently are not class members in the underlying lawsuits. The three-judge court acknowledged that its population cap was "likely" to require the release of an unspecified number of inmates who are not even arguably victims of the alleged constitutional harm. *Coleman*, 2009 WL 2430820, *77, 2009 U.S. Dist. LEXIS 67943, *272. But the vagueness of that statement obscured just how remarkable -- and indefensible -- the court's approach was.

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[8] It should go without saying that the factual allegations in these cases were more extensive than those in *Lewis* or even *Rizzo*, but again the most disturbing finding here concerned *past* conditions, and none of the findings here has been determined to involve an ongoing constitutional violation.

The three-judge court not only offered no estimate of how many class members were among the prisoners who would be released, it offered no estimate of how many class members there were to begin with. Thus, under the three-judge court's approach, it is possible that *none* of the class members would be among the 46,000 or so prisoners who would be released because of the court's order. And, perhaps even more troublingly, it is possible that *all* of the class members would be among the 46,000. For example, it is possible that there were only 35,000 class members to begin with, and that those 35,000 would be released along with 11,000 healthy prisoners.[9]

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[9] 35,000 is a purely hypothetical number, and likely dwarfs the number of prisoners with truly intensive needs, who present the most demand for the correctional system's healthcare resources. To amici's knowledge, no one -- not the three-judge court, nor even the parties themselves -- has a reliable, record-based estimate of the size of the total plaintiff class. While the prisoners presumably would attempt to put the number as high as possible, it is difficult to imagine how even they could reach 46,000 (to pick a less random number), except by double-counting prisoners who are members of both classes or by failing to distinguish between those prisoners who require very little care and those who require a great deal of care.

Of course, whether because of the state's legitimate choices or simple chance, the actual balance of class members and non-class members released pursuant to the three-judge court's order almost certainly would fall somewhere between those two extremes. But they nevertheless illustrate just how inconsistent the three-judge court's approach was with the terms of the PLRA, which again make clear that prisoner-release orders are prohibited unless they are the only possible relief, 18 U.S.C. § 3626(a)(3)(E)(ii); and that, when issued, they must be "narrowly drawn" and "extend[ ] no further than necessary to correct the violation of the Federal right...." 18 U.S.C. § 3626(a)(1)(A).[10]

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[10] Because the three-judge court failed to comply with the requirements of the PLRA, there is no need to rely on general caselaw on structural injunctions, which precedent has often developed in very dissimilar factual contexts. But even under such authority, the three-judge court's order again would be unsupportable. This is not a situation in which injunctive relief merely would have some "collateral" or "incidental" spillover effect benefiting individuals who are not victims of the alleged wrong. *Compare Missouri v. Jenkins*, 515 U.S 70, 110-11 (1995) (O'Connor, J., concurring). Rather, the three-judge court's order would *directly* benefit non-victims, and would do so on a massive scale. There is no legitimate basis for such an approach. *See* 42 U.S.C. § 1983 (state officials can only be liable "to the party injured...."); *Dayton Bd. of Educ. v. Brinkman*, 433 U.S. 406, 419-20 (1977) (scope of remedy is limited to scope of constitutional violation). And it would have the practical effect of doing indirectly what is forbidden directly -- expanding the classes to include prisoners who have suffered no injury, and consequently have no standing. *Cf. Schlesinger v. Reservists to Stop the War*, 418 U.S. 208, 222 (1974); *Blum v. Yaretsky*, 457 U.S. 991, 1001-02 (1982).

This is not to say, of course, that the three-judge court should have ordered the mass-release of prisoners with serious mental or physical illnesses. But if there was to be a remedy at all, it should have been narrowly drawn to directly address only the needs of such inmates. The three-judge court's order, which instead would most directly benefit prisoners who, unless by coincidence, are not even class members, is unsupportable under the PLRA.

III. Real-world experience with large-scale prisoner releases suggests that the three-judge court's order poses a significant threat to public safety.

The three-judge court's failure to decide these cases in a manner consistent with the requirements of the PLRA is troubling for many reasons, but the most palpable is the resulting threat to public safety. While the three-judge court has confidently declared that the state can release approximately 46,000 prisoners in a manner "that will not have an adverse impact on public safety, and that in fact may improve public safety," *Coleman*, 2009 WL 2430820, *84, 2009 U.S. Dist. LEXIS 67943, *293, real-world experience with large-scale prisoner releases shows otherwise. The documented effects of such an order in Philadelphia, which were well known to Congress when it enacted the PLRA,[11] are illustrative.

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[11] *See, e.g.*, Statement of Sen. Abraham, 141 Cong. Rec. 26352, 26448 (1995) ("American citizens are put at risk every day by court decrees. I have in mind particularly decrees that cure prison crowding by declaring that we must free dangerous criminals before they have served their time, or not (continued..

Pursuant to a consent decree in effect from 1986 until after the adoption of the PLRA in 1995, a federal district court judge enforced a population cap on the Philadelphia prison system that required the release or non-admittance of several hundred inmates per week.[12] Like her colleagues from California, the district court judge in Pennsylvania did not require local officials to indiscriminately "throw open the doors of [their] prisons." *Coleman*, 2009 WL 2430820, *78, 2009 U.S. Dist. LEXIS 67943, *274. Rather, she did essentially what the three-judge court proposes to do here, and what courts invariably have done when enforcing population caps: leave officials with no choice but to release (or not admit) the

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incarcerate certain criminals at all because prisons are too crowded. The most egregious example is the city of Philadelphia. For the past 8 years, a Federal judge has been overseeing the wholesale release of up to 600 criminal defendants per week ...."). Statement of Sen. Dole, 141 Cong. Rec. 26476, 26549 (Sep. 27, 1995) ("Perhaps the most pernicious form of micromanagement is the so-called prison population cap. ... [For example,] there's the case of Philadelphia, where a court-ordered prison cap has put thousands of violent criminals back on the city's streets, often with disastrous consequences").

[12] The consent decree was entered over the objection of local prosecutors (who had no guaranteed right of intervention prior to the PLRA), and despite the absence of any finding of ongoing constitutional violations in Philadelphia's prisons. *See Harris v. Pernsely*, 820 F.2d 592 (3d Cir. 1987); Prison Reform: Enhancing the Effectiveness of Incarceration. Hearings on S. 3, S. 38, S. 400, S. 866, S. 900 Before the Committee on the Judiciary, United States Senate, 104th Cong. 1st Sess. (Jul. 27, 1995) (testimony of Lynne Abraham, District Attorney of Philadelphia).

criminals seen as the best of the worst, such as those who had committed non-violent drug or property crimes, and those incarcerated because of probation or parole violations. *See* Violent Criminal Incarceration Act of 1995, Hearings on H.R. 667 Before the Committee on the Judiciary, United States House of Representatives, 104th Cong. 1st Sess. (Jan. 19, 1995) (testimony of Lynne Abraham, District Attorney of Philadelphia) (hereafter "Abraham House Testimony").

Yet the effect of the population cap on public safety was not the neutral or favorable one the three-judge court has predicted here. Rather, it was an extraordinary crime wave. During an eighteen-month period from January 1993 through June 1994 in which local officials took it upon themselves to document the consequences of the population cap, Philadelphia police rearrested 9,732 prisoners who had been released because of the cap. The new crimes those defendants were charged with committing during their premature releases included 79 murders, 1,113 assaults, 959 robberies, 701 burglaries, 90 rapes, 14 kidnappings, 264 firearms violations, 2,748 thefts, 2,215 drug-dealing offenses, and 127 counts of driving under the influence. Abraham House Testimony, *supra*; Statement of Sen. Dole, 141 Cong. Rec. at 26448.

Many of the victims of those crimes were residents of crime-plagued inner-city neighborhoods, whose suffering all too often escapes the notice of decisionmakers. *Cf. United States v. Pineda-Moreno,* 2010 WL 3169573 *3, 2010 U.S. App. LEXIS 16708, *9 (9th Cir. Aug. 12, 2010) (Kozinski, C.J., joined by Reinhardt, J., *et al.*, dissenting from denial of rehearing *en banc*) (observing that judges are among the members of society least likely to encounter the effects of court rulings that affect the public at large). But outrage over the population cap grew, and the need for prison litigation reform became glaringly apparent, when Daniel Boyle, a 21-year-old rookie police officer, was gunned down by Edward Bracey, a recently-released prisoner.

After his premature departure from jail, Bracey, a career car thief, promptly returned to his trade. When Officer Boyle attempted to stop him after one of his heists, Bracey led the young officer on a chase that ended with the thief crashing into a building. Unwilling to surrender even at that point, Bracey jumped out of his stolen car with a gun and fired eight times at Officer Boyle, including a fatal shot to the right temple. *See Commonwealth v. Bracey*, 662 A.2d 1062 (Pa. 1995); Violent Criminal Incarceration Act of 1995, Hearings on H.R. 667 Before the Committee on the Judiciary, United States House of Representatives, 104th Cong. 1st Sess. (Jan. 19, 1995) (testimony of Detective Patrick Boyle, father of Officer Boyle).

Several other police officers narrowly avoided similar fates. Officer Donald McMullen survived, albeit with a significant loss of vision, when released prisoner James Leath shot him in the face. *See* Wanda Motley and Julia Cass, *Council Hearings Examine Limit on Prison Population: Victims and Rendell vs. Guards and Inmates*, Philadelphia Inquirer, Sep. 29, 1994, at p. B1; Joseph A. Slobodzian, *Man Who Wounded Officer in '91 Gets Added Sentence: Life*, Philadelphia Inquirer, May 27, 1994, at p. B3. Similarly, Officer Bernard Murphy and his brother, Officer Shawn Murphy, survived the gunshot wounds they sustained when re-arresting Eddie Byrd, a released drug offender. *See* Dave Rascher, *Man Gets 20 Years for Shooting 2 Cops*, Philadelphia Daily News, Dec. 3, 1994, at p. 10. And Officer Raymond Shaw's bullet-proof vest saved his life when Robert Kirby, a drug-dealer freed thanks to the population cap, shot him during a marijuana bust. *See* Frank Dougherty, *Cop-Shooting Suspect Was Out of Jail on Cap*, Philadelphia Daily News, Nov. 8, 1995, at p. 7; Dave Racher, *Bulletproof Vest Saved Cop's Life -- And Spared Teen From a Murder Rap*, Philadelphia Daily News, May 15, 1996, at p. 15.

Of course, it was neither the intention nor the expectation of the district court in Philadelphia that imposing a population cap on the local prison system would lead to such violence against police and other innocent victims. Judicial intervention into prison affairs invariably begins with the best of intentions, often motivated by concerns over seemingly harsh sentencing practices or failures to comply with preferred standards for prison administration. But what the Philadelphia experience shows is that such concerns are best left to the people to address through the elected representatives responsible for shaping prison and criminal-justice policies.

At least some of the former prisoners who fired on Philadelphia police likely would have qualified for release under the three-judge court's order as well, as they all had been incarcerated in connection with non-violent offenses when they were freed because of the Philadelphia population cap. Indeed, the idea of such prisoners having been incarcerated at all for their drug and property crimes might well have been in tension with the three-judge court's view of enlightened criminal-justice policy. And yet those released prisoners and thousands of others in Philadelphia proved the prescience of then-Judge Alito's warning that, when, as here, the prosecuting authority does not believe that a large-scale prisoner release can be accomplished safely, "a court cognizant of its responsibilities to the community would hesitate to require the [state or local government] to follow a course of action that is antithetical to [its] most basic obligations and contrary to the public safety." *Harris v. City of Philadelphia*, 47 F.3d 1342, 1359 (3d Cir. 1995) (Alito, J., dissenting).

Unfortunately, the three-judge court's decision, for all its lengthy discussion of expert opinion, comes across as almost cavalier in its prediction that the public will be, if anything, *safer* with 46,000 more criminals on the streets. The lower court relied heavily on expert opinion to the effect that modestly-shorter prison terms would reduce deterrence only slightly. *See, e.g.*, *Coleman*, 2009 WL 2430820, *89, 2009 U.S. Dist. LEXIS 67943, *309. But compliance with the three-judge court's population cap would not be a discrete, one-time event. Rather, the state would have to comply with the cap indefinitely.[13] Thus, short-term deterrence, or even incapacitation, on an individual level is not the issue.

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[13] The three-judge court made clear, albeit not in the context of discussing the public-safety consequences of its order, that it expected the population cap to force a long-term reduction in the number of prisoners the state may hold. *See Coleman*, 2009 WL 2430820, *68, 2009 U.S. Dist. LEXIS 67943, *245. Under the court's decision, while the number of released (continued...

If the three-judge court's order were allowed to stand, the state would *constantly* have thousands more criminals on its streets than it would but for the order. That is not hyperbole; rather, it is the simplest explanation of what the order under review would mean in practice. To assert that such a state of affairs "will not have an adverse impact on public safety, and [ ] in fact may improve public safety," *Coleman*, 2009 WL 2430820, *84, 2009 U.S. Dist. LEXIS 67943, *293, is to depart from the PLRA, *see* 18 U.S.C. § 3626(a)(1)(A) ("The court shall give substantial weight to any adverse impact on public safety...."), and to forget the hard-earned lessons of history.

The simple and unambiguous terms of the PLRA make prisoner-releaser orders a remedy of last resort by restricting them to cases in which they are necessary and narrowly tailored to remedy an ongoing federal violation, and do not unreasonably threaten public safety. Because the three-judge court's decision does not comport with those basic statutory requirements, reversal is imperative.

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prisoners will fluctuate over time, and may even come down somewhat because of new prison construction or transfers of inmates to other states' facilities, it will remain very substantial for the foreseeable future.

CONCLUSION

The decision of the three-judge court should be reversed.

Respectfully submitted,

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IN THE
Supreme Court of the United States

ARNOLD SCHWARZENEGGER,

Governor of California, et al.,

Appellants,

v.

MARCIANO PLATA and RALPH COLEMAN, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURTS FOR THE EASTERN DISTRICT AND NORTHERN DISTRICT OF CALIFORNIA

BRIEF FOR PRISON FELLOWSHIP, ALEPH INSTITUTE, AMERICAN FRIENDS SERVICE COMMITTEE, CALIFORNIA COUNCIL OF CHURCHES, FRIENDS COMMITTEE ON LEGISLATION OF CALIFORNIA, GENERAL SYNOD OF THE UNITED CHURCH OF CHRIST, ISLAMIC SHURA COUNCIL OF SOUTHERN CALIFORNIA, LEADERSHIP CONFERENCE OF WOMEN RELIGIOUS, NATIONAL ASSOCIATION OF EVANGELICALS, NATIONAL COUNCIL OF CHURCHES, PAULIST NATIONAL CATHOLIC EVANGELIZATION ASSOCIATION, PROGRESSIVE JEWISH ALLIANCE, SOJOURNERS, UNION FOR REFORM JUDAISM, AND UNITARIAN UNIVERSALIST ASSOCIATION AS AMICI CURIAE IN SUPPORT OF APPELLEES

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INTERESTS OF AMICI CURIAE

Amici Curiae who submit this brief are religious organizations whose belief systems, while diverse, all emphasize the intrinsic value of every human being and the importance of a legal system that upholds constitutional principles even, or especially, when applied to those whose transgressions would otherwise make them easy targets for maltreatment.[1] Several Amici have active prison ministries that facilitate prayer groups, Bible studies, or group worship. Many have a concern with adequate health care generally and for inmates specifically.

Despite the subtle, or significant, differences among their beliefs or ministries, these Christian, Muslim, and Jewish Amici agree on two issues relevant to this appeal. First, they share a faith-based duty to ameliorate unnecessary human suffering, especially among the marginalized, such as the inmates in the California prison system. The inhumane conditions in the California prison system, caused primarily by overcrowding, lead to unnecessary deaths, including suicides, and a host of other unjustified and avoidable harms and affronts to human dignity.

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1. Counsel for all parties have consented to the filing of this brief, and those consents have been filed with the Clerk of this Court. No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No one other than Amici Curiae, or their counsel, made a monetary contribution intended to fund its preparation or submission.

Because these inhumane and unconstitutional conditions have persisted year after year and despite every previous attempt to correct them, Amici call for an immediate and effective remedy as authorized by the Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626(a)(3). It has been fifteen years since the court held in *Coleman* that the California prison system's treatment of its inmates' mental illnesses violated the Constitution. Since 1995 the California prison system's mental health care has worsened. Eight years ago, California consented to judgment that its health care system for inmates violated the Constitution. Since 2002 the health care system in California prisons has deteriorated.

The PLRA authorizes a prisoner release order in these circumstances. As a precondition to such an order, the PLRA requires that a prior court order mandating less intrusive relief has failed. 18 U.S.C. § 3626(a)(3)(A)(i). In *Coleman* more than seventy orders have issued, but the confinement in cages and the foreseeable and preventable suicides continue. Despite the many orders issued in *Plata*, the extreme departures from the standard of care and unnecessary deaths continue. The PLRA requires that the defendant have a reasonable amount of time to remedy the violations. 18 U.S.C. § 3626(a)(3)(A)(ii). California has had eight years in *Plata* and fifteen years in *Coleman* to remedy the violations. It has not done so. The PLRA requires the court to find that overcrowding is the primary cause of the violation and that no other form of relief will remedy the violation. 18 U.S.C. § 3626(a)(3)(E)(i)-(ii). The Three-Judge Court so found, and its findings are overwhelmingly supported in the record. If this Court holds that a prisoner release order is not called for in this case, it is painful to imagine circumstances egregious enough, or prolonged enough, to justify such an order. In these circumstances, the federal courts must have the power to remedy entrenched constitutional violations and thereby stop the unjustified and avoidable suffering.

An additional consequence of the extreme overcrowding in the California prison system is its detrimental effect on religious practices. Congress has specifically protected inmates' rights to religious exercise under the Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA), 42 U.S.C. §§ 2000cc to 2000cc-5. For many prisoners, the path from wrongdoing to rehabilitation runs through faith and religious practice. They depend on volunteers, like those associated with several Amici, who lead them in worship; study the Bible, Qur'an, or other sacred texts with them; and help them to develop the moral compass they need to guide them to a safe, productive, and responsible life, both within the institution and after their release. The freedom to practice their faith can be critical to restoring inmates' sense of hope and purpose while also bringing greater order to the prisons and more security to our communities. It is for these reasons that many Amici consider prison ministry to be a fundamental element of their religious mission and of the practice of their own faiths.

And yet the overcrowded conditions and excessive use of lockdowns in California prisons choke off meaningful opportunities for religious worship and observance. When every available square foot is used for triple-bunking, there is simply no room for religious, educational, or other rehabilitative programming. Lockdowns also prevent religious volunteers from entering the prisons, thereby shutting out the guidance, solace, compassion, and rehabilitative influence they bring. Overcrowding in the California prisons has thus stifled inmates' religious exercise, in addition to depriving them of constitutionally sufficient health care. As the violations multiply, the moral and legal imperative to remedy the overcrowding intensifies. Congress authorized prisoner release orders in the PLRA for just such cases as this, so that federal courts can adopt a meaningful remedy when all other attempts to end the unconstitutional conditions and attendant suffering have failed.

ARGUMENT

I. The Unconscionable Conditions in the California Prison System Regarding Medical and Mental Health Care Violate Both Constitutional and Humane Standards and Must Be Remedied.

California has failed for decades to provide constitutionally adequate medical and mental health care to its inmates, resulting in the unnecessary and wanton infliction of pain. Inmates in need of significant mental health treatment are confined in "dry cells" – a euphemism for cages – because beds are not available. California has a shameful record of dealing with foreseeable and preventable suicides. Inmates who become seriously ill die for lack of proper treatment, as of mid-2005 at the rate of more than one per week.

The Constitution requires that California "provide humane conditions of confinement." *Farmer*, 511 U.S.

at 832. This mandate includes an obligation to provide medical care for its inmates. *Estelle*, 429 U.S. at 103. For more than thirty years, this Court has recognized that a prison system's failure to provide for inmates' medical care results in pain and suffering, leading in the worst cases to a "lingering death." *Id.* (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

As this Court stated in *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189, 199–200 (1989):

> [W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. . . . The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – *e.g.*, food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment . . . .

For too long, California's prisons have failed to provide for the "basic human needs" of the inmates in their charge.

The harms that befall prisoners are not part of any assessed punishment. No inmate is sentenced to the as "dry cells," these structures are in fact cages. *Id.* at 98a–99a (citing *Coleman*-D.E. 3201 ¶ 156 (Prof. Craig Haney, Rep., Aug. 15, 2008)). See image below.

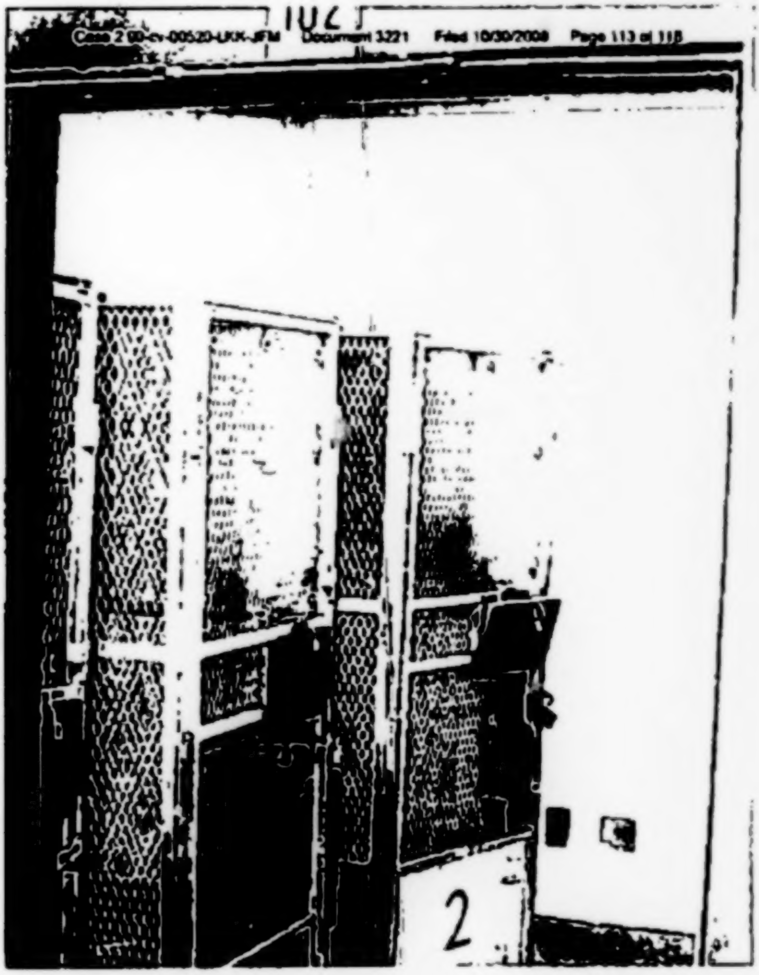
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Image from *Coleman*-D.E. 3221 App. C (Pablo Stewart, M.D., Supp. Rep., Aug. 15, 2008). These cages have no toilets, sinks, or beds. *Coleman*-D.E. 3201 ¶ 106; *Coleman*-D.E. 3217 ¶ 141 (Pablo Stewart, M.D., Rep., Nov. 9, 2007). Suicidal inmates are confined in these cages for days, waiting for treatment beds. While waiting, they are shuttled at night to "wet cells," which have toilets and beds for sleeping, before transfer back

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to the cages the next day. JS1-App. 98a–99a. The most seriously mentally ill wait for up to a year to be transferred to inpatient beds. *Id.* at 98a (citing *Coleman*-D.E. 3221 ¶ 20).

The Three-Judge Court found that the California prison system has an elevated rate of suicides as compared to the national prison average. JS1-App. 123a (citing P-58 at 9 (Raymond F. Patterson, M.D., Rep. on Suicides Completed in the CDCR (California Department of Corrections and Rehabilitation) in 2006, filed Sept. 12, 2008)). The evidence shows that in 2006, the California prison system suicide rate of 25.1 per 100,000 inmates was almost 80% higher than the national average of 14 per 100,000. *Id.* at 123a (citing P-58 at 9). And, significantly, 72.1% of those suicides were foreseeable and probably preventable. JS1-App. 124a. In the first ten months of 2008, directly before the start of the November 2008 trial, the suicide rate remained high, at 24 suicides per 100,000 inmates per year. *Id.* at 124a n.53.

The record on general medical care is equally appalling. The Three-Judge Court found that 40% of "unexpected" deaths (excluding suicides and homicides) were preventable or possibly preventable. *Id.* at 124a–125a (citing D-1233 at 8 (Kent Imai, M.D., Analysis of Year 2007 Death Reviews, Nov. 3, 2008)). Sixty percent involved "extreme departures" from the standard of care. *Id.* at 125a.

Like mentally ill inmates, those with physical infirmities are forced to wait too long for medically necessary treatment. *Id.* at 9a. At one facility, only 0.6%

of inmates with "urgent referrals" are seen by medical providers within the fourteen-day period prescribed by CDCR policy. *Id.* at 115a (citing *Coleman*-D.E. 3231-14 ¶ 65 (Ronald M. Shansky, M.D., Rep., Nov. 9, 2007)). These delays can and do cause death. Typical situations include a death caused by a two-year delay in diagnosis of testicular cancer in an inmate with chronic testicular pain, a death from failure to treat an inmate who presented nine times over three days with severe abdominal pain, and death from the failure of the on-call physician to come for over eight hours to attend to an inmate with constant and extreme chest pain. P-34 at 6 (Kent Imai, Analysis of CDCR Death Reviews, Aug. 20, 2007).

The record thus establishes that for many years, up to and including the months before the trial in the Three-Judge Court, conditions in the California prison system not only fell below minimum constitutional standards but also inflicted on the inmates severe and unnecessary pain and suffering. *See, e.g.*, *Coleman*-D.E. 3221 (describing conditions as of July and August, 2008); *Coleman*-D.E. 3231-15 (Jeanne Woodford, Supp. Rep., Aug. 15, 2008) (same); *Coleman*-D.E. 3231-9 (Doyle Wayne Scott, Supp. Rep., Aug. 13, 2008) (describing conditions as of June 2008).

This Court has held that the Eighth Amendment prohibits the imposition of punishments that are grossly out of proportion to the crime. *See Ewing v. California*, 538 U.S. 11, 20–23 (2003) (plurality opinion) (reviewing history of proportionality principle in case law). Amici endorse society's need to impose fitting punishments for criminal behavior. Those who conduct prison ministries help inmates to accept responsibility for their crimes and to seek forgiveness. But California's conditions of confinement are not rationally related to criminal behavior and just punishment. No court or legislature has determined that any inmate deserves to endure repeated cycles of psychosis or untreated infection in penance for his crime. Such suffering is meted out by chance to those inmates unfortunate enough to get sick or need mental health care in a California prison.

There is no societal justification for such arbitrary and cruel conditions of confinement. As set forth below, the record is clear that overcrowding is the primary cause for these inhumane conditions and, unless overcrowding is reduced, the infliction of unnecessary pain and suffering will continue. Without a prisoner release order, California's prisoners can have no hope of a real end to their already prolonged and inexcusable suffering.

B. The Three-Judge Court Correctly Concluded That the PLRA Authorizes a Prisoner Release Order To Remedy Longstanding and Intractable Violations That Result Primarily from Overcrowding.

In enacting the PLRA, Congress did not intend to make prisoner lawsuits impossible or to cut off vital remedies, because "[o]ur legal system . . . remains committed to guaranteeing that prisoner claims of illegal conduct by their custodians are fairly handled according to law." *Jones v. Bock*, 549 U.S. 199, 202 (2007). Most pertinent here, Congress did not ban prisoner release orders. Instead, it set forth the terms under which courts may issue such orders, setting the bar high to make this a remedy of last resort. California attempts, however, to raise the bar beyond what Congress intended or what any litigant may vault. This attempt to vitiate the final remedy authorized by the PLRA cannot succeed.

The PLRA establishes four requirements for the issuance of a prisoner release order: (1) a prior order for less intrusive relief has failed; (2) the defendant has had sufficient time to remedy the violation; (3) "crowding is the primary cause of the violation;" and (4) "no other relief will remedy the violation." 18 U.S.C. § 3626(a)(3)(A)(i)–(ii), (a)(3)(E)(i)–(ii). The Three-Judge Court properly held that all four requirements are met here.[5]

1. Prior orders for less intrusive relief have failed.

Numerous prior orders for less intrusive relief issued by the *Coleman* and *Plata* Courts have failed. The Three-Judge Court found that, during nearly two decades of litigation, the *Coleman* Court had issued more than seventy orders. JS1-App. 31a. Yet California

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[5] These first two prerequisites for a prisoner release order are also the preconditions for convening a three-judge court with the authority to issue such an order. 18 U.S.C. § 3626(a)(3)(C), (D). Amici adopt the position of the Plaintiffs-Appellees that the decision to convene a three-judge court is not reviewable in this Court. *See Coleman* Appellees' Br. 35-39. Amici nevertheless address the first two PLRA requirements insofar as they relate to the justification for the prisoner release order issued below.

"still cannot provide thousands of mentally ill inmates with constitutionally adequate mental health care." *Id.*

The Three-Judge Court also found that, despite a stipulation for injunctive relief, the appointment of a Receiver, and numerous orders, ***not a single prison has successfully completed implementation of the stipulated remedy*** in *Plata*. *Id.* at 15a–17a. This was true as of May 2005, when twelve prisons were supposed to have come into compliance under the stipulated implementation schedule, and the Three-Judge Court found that "[it] remains true now, more than seven years after the court approved the parties' settlement agreement." *Id.* at 17a.

In sum, "[a]ll of the steps defendants have taken under the *Plata* court's supervision, as well as the steps taken under the *Coleman* court's supervision, have failed to remedy the constitutional deficiencies." *Id.* at 141a.

2. California has had sufficient time to remedy the violations.

California has had years and years to remedy the violations while inmates continue to decline and die. Fifteen years to develop adequate mental health care is too long. Eight years is too long to bring even one of California's prisons into compliance with the remedy that California stipulated to implement. The *Plata* Receiver advised the court that "[California] had ample opportunity to improve medical conditions, [but] it failed to do so." D-1092 at 2 (Receiver's Rep. re Overcrowding, May 14, 2007). The *Coleman* Special Master bemoaned "the long struggle to remedy the faults [in mental health care] so glaringly revealed in the [*Coleman*] trial . . . in the mid-1990s." D-1292 at 4.

California argues that it has had insufficient time to respond to the very last orders issued in *Coleman* and *Plata*, complaining in particular of a lack of opportunity to implement the *Plata* Receiver's plan. State Br. 15–16, 21–22. But the PLRA does not require a court to ignore years of failure to comply with multiple orders. The Three-Judge Court concluded that neither the *Plata* Receiver nor the *Coleman* Special Master could produce an effective remedy unless overcrowding was reduced. JS1 App. 143a–145a. The State is not entitled to an endless series of failures, or a years-long hiatus to test whether it will fail yet again to comply with the last remedial order, before a prisoner release order may issue. It is enough that the Three-Judge Court found that the State has repeatedly failed to comply with less onerous orders and that it will continue to do so until overcrowding is reduced.

3. Overcrowding is the primary cause of the violations.

The Three-Judge Court correctly concluded that overcrowding is the primary cause of the violations in the California prison system. *Id.* at 140a–141a. Indeed, the Three-Judge Court found that California had designed the system in a manner destined to produce constitutionally inadequate health care for the anticipated population. *See id.* at 57a. From the 1980s forward, California designed its prisons to house the anticipated excess population, but not to treat them.

Id. at 57a–58a. The prison infrastructures for water, wastewater, electrical, and mechanical systems were designed to accommodate 190% of design capacity in celled prisons and 140% in dormitory prisons. *Id.* at 57a. No accommodation was made, however, for the extra medical and clinical areas this excess population would require. *Id.* at 58a. Moreover, none of the nineteen prisons built in the 1980s and 1990s gave any consideration whatsoever to space for mental health care and treatment. *Id.* (quoting D 1292 at 4–5). Even in 2005, a decade after the *Coleman* judgment and three years after the *Plata* stipulated judgment, California built a prison with full knowledge that the medical and mental health space would be entirely insufficient for the actual inmate population. *Id.* at 176a–177a.

The decision not to provide adequate space for medical and mental health care led, unsurprisingly, to a system that cannot deliver constitutional care to the number of inmates it houses. Seven experts, including four former or current state prison system administrators, testified that overcrowding is the primary cause of the violations and the greatest obstacle to any successful remedy. *Id.* at 126a–133a. California's medical expert was the only one who did not identify overcrowding as the primary cause of the violation, *id.* at 133a, but the Three Judge Court found his opinions to be "overwhelmingly outweighed by the testimony of the numerous other, more qualified experts." *Id.* at 136a. California's mental health expert agreed that overcrowding was the primary cause of constitutional violations in the reception centers through which inmates enter the system (and where they often remain for months). *Id.* at 138a, 90a–92a. Ultimately, the court concluded that "'[o]vercrowding is the one factor that negatively impacts almost every other matter that must be addressed to create a minimally adequate medical care delivery system for California's prisons.'" *Id.* at 134a (quoting *Coleman*-D.E. 3231-13 ¶ 9 (Ronald M. Shansky, M.D., 2d Supp. Rep., Sept. 10, 2008)).

California responds with a strained attempt to rewrite the PLRA to require a finding that overcrowding is the sole cause of the violations such that "eliminating crowding *alone*" should effect a remedy. State Br. at 30 (emphasis added). This is not what the PLRA requires. As the Three-Judge Court noted, "We need not find that crowding is the *only* cause, but simply that it is the *primary* one. In the end, we agree with the former Executive Director of the Texas Department of Corrections Doyle Wayne Scott, who testified that 'everything revolves around overcrowding.'" JS1-App. 143a (citations omitted).

4. No other relief will remedy the violations.

The Three-Judge Court found that no other relief will remedy the constitutional violations. *Id.* at 143a–168a. The need to address overcrowding is best stated by the *Coleman* Special Master. He notes that over the past fifteen years much effort to remedy the mental health system has occurred, but "many of the achievements have succumbed to the inexorably rising tide of population, leaving behind growing frustration and despair." D-1292 at 16–17. Likewise, in his May 2007 Report re Overcrowding, the *Plata* Receiver advised the court that, absent a prisoner release order, "'the cost and the scope of intrusion by the Federal Court cannot help but increase, and increase in a very significant manner,'" to remedy the violations. JS1-App. 156a (quoting D-1092 at 41). In fact, the Receiver opined that it might "'all but bankrupt the State of California'" just to create a medical system adequate to serve the current population coming through the reception center at the California Institute for Men. *Id.* (quoting D-1092 at 41). The Three-Judge Court thus reasonably concluded that "relying on the authority that [the Receiver] possesses to resolve the medical care crisis in the absence of a population reduction order does not offer a feasible alternative." *Id.*

Thus, the PLRA allows the issuance of a prisoner release order here. If a federal court cannot issue a prisoner release order in this case, then no facts could justify such an order, and the PLRA's authorization of this final remedy is meaningless. Yet, when a constitutional violation has gone unremedied for many years despite repeated efforts to correct it, "the court has not merely the power but the duty to render a decree which will so far as possible eliminate [the wrong]." *Louisiana v. United States*, 380 U.S. 145, 154 (1965) (affirming order requiring state to remove barriers to voting by African Americans). This Court has before been called upon to make clear when "'[t]he time for mere "deliberate speed" has run out,'" and the time has arrived for "a plan that promises realistically to work, and promises realistically to work now." *Green v. County Sch. Bd.*, 391 U.S. 430, 438–39 (1968) (citation omitted) (requiring school board to adopt effective remedy for segregation fourteen years after decision in *Brown v. Board of Education*, 347 U.S. 483 (1954)).

II. Overcrowding in the California Prison System Also Harms Inmates by Interfering with Their Practice of Religion and Diminishing Their Prospects for Rehabilitation.

In addition to creating abhorrent living conditions and constitutionally deficient medical and mental health care systems, overcrowding in the California prison system also threatens other important rights and interests central to the missions of Amici. The extreme lack of space and resources caused by overcrowding often prevents inmates of faith from assembling with their fellow congregants and keeps out those, including some Amici, who would minister to them. The result is an impairment of inmates' religious observance and practice, including deprivation of rehabilitative religious programming and counseling. As conditions now stand, California will continue to witness only a deepening of the despair and hopelessness that plague its prisons.

No claim for the infringement of religious rights was asserted in this case, and Amici do not seek to insert one. Their aim instead is to highlight for the Court that the crisis-level overcrowding in the California prisons leads to the sacrifice, not only of prisoners' health, but also of their religious practice. This additional, serious harm further supports the prisoners' plea for an affirmance in this case. Federal courts must have the power to order population reductions when overcrowding is so extreme as to nullify other remedies, leaving prisoners to suffer needlessly in mind, body, and spirit.

A. Both the Constitution and Federal Law Protect Inmates' Practice of Religion.

The First Amendment right of individuals to freely exercise their religion has long been held among the most fundamental American principles. *See, e.g.*, *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 523 (1993) ("The principle that government may not enact laws that suppress religious belief or practice is so well understood that few violations are recorded in our opinions."). As this Court has recognized, although prisoners must surrender many liberties, "[p]rison walls do not form a barrier separating prison inmates from the protections of the Constitution." *Turner v. Safley*, 482 U.S. 78, 84 (1987).

A central component of nearly every religion is the ability to gather with fellow congregants and engage in group worship and observance. Roman Catholics, for example, have an obligation to attend Mass at least weekly on Sundays, as well as on special feast days. *Catechism of the Catholic Church* ¶¶ 1389, 2180 (2d ed. 2003). Many other Christian denominations, sharing the tradition of Sunday meetings, also follow the Bible's instruction to come together: "[L]et us consider how to stir up one another to love and good works, not neglecting to meet together, as is the habit of some, but encouraging one another, and all the more as you see the Day drawing near." *Hebrews* 10:24–25. These Christian practices reflect the teachings of Christ that "where two or three are gathered in my name, there am I in the midst of them." *Matthew* 18:20. The call to gather for worship is also essential to Judaism. A minyan, or quorum of ten individuals over thirteen years old, is necessary before a Jewish community can properly offer its prayer. *See, e.g.*, *Mishnah, Megillah*, 4, 3. Moreover, a Jew "must associate himself with the congregation, and not recite his prayers by himself anytime he is able to pray with the congregation." Maimonides, *Hilkhot T'fillah* 8:1. Islam too places a high value on assembly of the faithful for prayer. Muslim scholars agree that the Jumu'ah, a Friday gathering replacing the usual midday prayer, is an obligation on each individual Muslim. *See, e.g.*, Abd al-Rahman al-Jaziri, *al-Fiqh ala al-Madhabib al-Arba'ah* 375 (Ihya' al-Turath al-Arabi, Beirut). They point to the Qur'an's instruction, when the call for prayer goes out, to "come to the remembrance of Allah and leave off business." *Qur'an* 62:9.

In recognition of these basic tenets of faith, this Court has acknowledged that "'[t]he exercise of religion often involves not only belief and profession but the performance of physical acts [such as] assembling with others for a worship service [or] participating in sacramental use of bread and wine.'" *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005) (quoting *Emp't Div. v. Smith*, 494 U.S. 872, 877 (1990)). The special difficulties inmates face in practicing their faith are highlighted in an encounter Charles Colson, founder of Amicus Prison Fellowship, had with one corrections official who was resistant to accommodating group worship:

> He said, "Anybody can go in their cell and practice their own religious beliefs in their own ways," and he simply reflects a misunderstanding of what Christianity is,

> because Christianity is a communal religion. It is one in which we have to be together to practice our faith; to administer the sacraments, and to be part of a community of believers; that's what Christian faith is. So, you can't do it just by worshipping privately in your cell.

Protecting Religious Freedom After Boerne v. Flores*: Hearing Before the Subcomm. on the Const. of the H. Comm. on the Judiciary*, 105th Cong. 7 (July 14, 1997) (testimony of Charles W. Colson, President, Prison Fellowship), *available at* http://commdocs.house.gov/committees/judiciary/hju50378.000/hju50378_0f.htm.

Federal law also recognizes that prisoners, whose existence is fraught with despair and despondency, are in particular need of the freedom to practice their faith. RLUIPA prohibits the government from imposing a "substantial burden" on a prisoner's "religious exercise" unless prison officials can demonstrate that burdening religious exercise is the "least restrictive means" of furthering a "compelling governmental interest." 42 U.S.C. § 2000cc-1(a)(1)–(2). Congress provided this extra measure of protection to prisoners and other institutionalized persons because they are particularly vulnerable to having their religious freedoms stripped away by government. 146 Cong. Rec. S7774, S7775 (2000) (joint statement of Sens. Hatch and Kennedy) (inmate's "right to practice [his or her] faith is at the mercy of those running the institution . . . . Whether from indifference, ignorance, bigotry, or lack of resources, some institutions restrict religious liberty in egregious and unnecessary ways."); 146 Cong. Rec.

H7190-02 (2000) (statement of Rep. Canady) (RLUIPA was designed to "protect the religious exercise of a class of people particularly vulnerable to government regulation, and that is institutionalized persons.").

This Court has identified the statute's core purpose: "RLUIPA thus protects institutionalized persons who are unable freely to attend to their religious needs and are therefore dependent on the government's permission and accommodation for exercise of their religion." *Cutter*, 544 U.S. at 721. Effecting this purpose, the Circuit Courts have applied RLUIPA specifically to protect group religious practice in the prison system. *See, e.g.*, *Greene v. Solano County Jail*, 513 F.3d 982, 988 (9th Cir. 2008) (finding that prison policy prohibiting maximum security prisoners from attending group religious services substantially burdened inmate's RLUIPA rights); *Lovelace v. Lee*, 472 F.3d 174, 187 (4th Cir. 2006) (concluding that disallowing prisoner from group Ramadan observance substantially burdened his RLUIPA rights); *Murphy v. Mo. Dep't of Corrs.*, 372 F.3d 979, 988–89 (8th Cir. 2004) (remanding for determination of whether denial of opportunity for communal worship violated RLUIPA). The unavoidable reality is that prisoners – no matter how hard they try or how sincere their belief – cannot practice their faith, including attending the worship services of their choice, without an accommodation by the prison.

B. Overcrowding Limits the Space and Resources Available for Religious Services and Programming.

As a result of overcrowding, inmates are crammed in nearly every corner of the California prisons, including public areas and corridors, with the result that space is unavailable "for anything but the warehousing of bodies." *Coleman*-D.E. 3231-10 ¶ 10 (Doyle Wayne Scott, Rep., Nov. 9, 2007). Indeed, the Three-Judge Court expressly found that these conditions have crowded out the space that would otherwise be available to accommodate inmate programming, which includes the group exercise of religion and religious programming. JS1-App. 103a ("[N]on-traditional beds are frequently created by 'converting activity space into inmate housing areas,' which adversely impacts all inmates by reducing the amount of space available for programs.") (quoting P-4 at 124 (Reforming Corrections, Rep. of the Corrections Independent Review Panel, June 2004)). Even Governor Schwarzenegger, a Defendant in this action, issued an Emergency Proclamation acknowledging that the "CDCR must house prisoners in areas never designed or intended for inmate housing, including gyms, dayrooms, and program rooms." P-1 at 1 (Prison Overcrowding State of Emergency Proclamation, Oct. 4, 2006).

Moreover, California prisons' heavy reliance on lockdowns further impairs the exercise of religion and the provision of programming. Lockdowns occur at an alarming rate in the California prison system, with a total of 449 lockdowns in 2006 alone. JS1-App. 116a (quoting Tr. 218:18–19, 20–25 (Jeffrey A. Beard, Ph.D.)). According to the Three-Judge Court, lockdowns can continue day after day for weeks and even months, with some housing units in a state of lockdown more often than they are not. *Id.* at 117a (quoting Tr. 316:23–317:9 (Prof. Craig Haney)). Not surprisingly, inmates in locked-down units "are essentially without programs during the periods of time that the lockdown is in place." *Id.* at 117a (quoting Tr. 316:23–317:9 (Haney)). The record in this case establishes that lockdowns interfere with religious services and other activities. For example, the Special Master specifically observed that inmates under lockdown were unable to participate in group worship services. P-57 at 84 (20th Monitoring Rep. of Special Master, Sept. 12, 2008); *see also* Mason Stockstill, *Chaplain: Prison's move may have led to violence*, Whittier Daily News, Jan. 20, 2005 (Spokesman for one California prison noted, "if part of [the prison] goes on lockdown, religious services as well as visitations can be suspended.").

This lack of programming undermines safety within the prisons, endangering inmates, staff, and volunteers. California prisoners suffer from extreme levels of "[i]solation, seclusion, idleness, violence, fear and stress." JS1-App. 132a (quoting *Coleman*-D.E. 3221 ¶ 117). The CDCR has itself acknowledged that a veritable powder keg results when access to programming and counseling is choked off: "Idleness-related frustration increases the probability of interpersonal conflict and assaults in prison." P-72 at 15 (CDCR, *Presentation to Senate Select Committee on Prison Population Management and Capacity* (Aug. 15, 2006)). Increased levels of violence may deter volunteers, including those who minister to prisoners, from entering the institutions and may trigger yet another cycle of lockdowns, excluding volunteers altogether. As one long-time volunteer with the Aleph Institute explains, while he looks forward to returning to a California prison each year, "[y]ou can't kid yourself. It's difficult work. Security, clearance, it's always a hassle, and you're always limited to certain times. They could have a lockdown and you'll be sent away. But you know when you get there and do it, you're making a difference." Jessica Naiman, *As Yom Kippur Nears, Needs of Jewish Prisoners in Spotlight*, Chabad.org, Sept. 15, 2010, *available at* http://www.chabad.org/news/article_cdo/aid/1302641/jewish/Yom-Kippur-Behind-Bars.htm.

C. When Religious Services and Programming Are Crowded Out, Those – Like Amici – Who Minister to Prisoners Are Frustrated in Fulfilling Their Religious Mission, to the Detriment of Prisoners, Prisons, and the Community.

As this Court has observed, "since most offenders will eventually return to society, another paramount objective of the corrections system is the rehabilitation of those committed to its custody." *Pell v. Procunier*, 417 U.S. 817, 823 (1974). Without successful rehabilitation, prisoners are released only to reoffend and return. The Three-Judge Court found that overcrowding in the California prisons produces conditions in which "high-risk inmates do not rehabilitate and low-risk inmates learn new criminal behavior." JS1-App. at 190a. The State's own Rehabilitation Strike Team issued a December 2007 report noting that "'fully 50% of all exiting California prisoners did not participate in *any* rehabilitation or work program . . . during their entire prison term.'" *Id.* at 189a (quoting P-113 at 13) (quoting P-4 at 124 (*Meeting the Challenges of Rehabilitation in California's Prison and Parole System: A Report from Governor Schwarzenegger's Rehabilitation Strike Team*, Dec. 2007)). As a result, Criminal Offenders, *supra*, 11, 27 ("[A]n inmate's chance of committing an infraction goes down as his rate of attendance at any religious program goes up . . . . [T]he more religious sessions the men attended the better the chance that they had no infractions."). Further empirical research points to a correlation between religious programming and successful rehabilitative efforts, including a reduction in recidivism. Byron R. Johnson, *Religious Programs and Recidivism Among Former Inmates in Prison Fellowship Programs: A Long-Term Follow-Up Study*, 21 Just. Q. 329, 343 (2004) (finding reductions in short-term re-arrest rate among most frequent participants in Bible study). Positive impacts are only realized, however, by the availability of consistent and immersive programming – exactly what is lost due to California's "warehousing of bodies" approach to incarceration. O'Connor & Perreyclear, *supra*, at 28 ("If inmates are to benefit from [religious programming], it seems they must become involved at a certain level of intensity. Mere attendance at the odd worship service, Bible study, or Jumuah prayer simply is not enough to bring about change or development.").

Many correctional administrators likewise recognize that religious practice can be instrumental in maintaining inmates' sense of hope and purpose. Staff at San Quentin State Prison "report that the religious activities help to instill in inmates morals [and] values and contribute to behavioral changes that are critical to their success as parolees and the safety of the community. As one official described the dynamic: 'Same mind, same results; changed mind, changed results.'" D-772 at 48 (Cal. Little Hoover Comm'n, *Back to the Community: Safe & Sound Parole Policies* (2003)). The

CDCR has found that inmates who choose to participate in religious programming are less apt to have behavioral problems. P-173 at 20 (CDCR, *Inmate Population, Rehabilitation, and Housing Management Plan* (2006)); *see also* Scott Smith, *An Appeal to the Divine: Whatever's in Their Past, Whatever Their Motivation, Faith Finds a Way Between the Bars*, Stockton Record, July 12, 2009 (reporting recognition by CDCR official that free exercise of religion has positive impact on inmates' lives). Moreover, an expert panel assembled by the CDCR recognized that successful rehabilitation and reentry are supported by forging bonds between inmates and their communities, which is a key aspect of religious programming and prison ministry. D-652 at 19 (CDCR, *A Roadmap for Effective Offender Programming in California* (2007)) ("The state should empower the community – families, neighborhoods, religious and cultural institutions, businesses – to reduce crime through deliberate efforts that assist offenders under correctional control and provide support to reduce criminal behavior.")).

By stifling religious services and programs, and shutting out those who would minister to prisoners, the California prison system's endemic overcrowding does more than cause physical and mental suffering. It poses an obstacle to the rehabilitation and redemption of inmates who would otherwise choose to practice their faith. This deprivation only exacerbates the despair that permeates the California prison system. Federal courts must not look away from their obligation to restore constitutional protections to inmates when other remedies have failed.

CONCLUSION

For these reasons, Amici respectfully urge the Court to affirm the order of the Three-Judge Court.

Respectfully submitted,

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APPENDIX

APPENDIX A — STATEMENTS OF INTEREST OF AMICI CURIAE

PRISON FELLOWSHIP

Amicus Curiae Prison Fellowship (PF) is the largest prison ministry in the world, partnering with thousands of churches and tens of thousands of volunteers in caring for prisoners, ex-prisoners, and their families. Founded thirty years ago by Chuck Colson, who served as special counsel to President Nixon and went to prison in 1975 for Watergate-related crimes, PF carries out its mission both in service to Jesus Christ and in contribution to restoring peace to our communities endangered by crime. Among other things, PF: (i) provides in-prison seminars and special events that expose prisoners to the Gospel, teach biblical values and their application, and develop leadership qualities and life skills; (ii) develops mentoring relationships that help prisoners mature through coaching and accountability; and (iii) supports released prisoners in a successful restoration to their families and society. As founder Chuck Colson has explained, "God has given us a vision and a ministry to go to the last, the least, and the lost of our society and bring hope to them."

ALEPH INSTITUTE

Amicus Curiae Aleph Institute is a non-profit Jewish educational, humanitarian, and advocacy organization. Aleph provides educational materials to the children of Jewish inmates; counseling to spouses, parents, and children; and financial assistance to families in need. The Spark of Light program is the only national program that serves Jewish people incarcerated in the United States to ensure that they stay connected to their families, communities, and Jewish heritage. Spark of Light social programs and services provide for the religious, rehabilitation, and humanitarian needs of individuals and their families from the moment of arrest, during the pre-sentencing stage and trial, and throughout their imprisonment. Spark of Light helps inmates amend their wrongs, seek forgiveness, and have the best possible opportunity to return to society as purposeful, responsible people.

AMERICAN FRIENDS SERVICE COMMITTEE

Amicus Curiae American Friends Service Committee (AFSC) is a Quaker organization, founded in 1917, that includes people of various faiths committed to social justice, peace, and humanitarian service. AFSC is guided by belief in the worth of every person and faith in the power of love to overcome violence and injustice. AFSC Healing Justice Programs provide services to prisoners and their families, and conduct research, public education, and advocacy on conditions of confinement, alternatives to incarceration, mitigating prison violence, and enabling successful prisoner re-entry. AFSC has engaged in such work for over a half-century in California. AFSC believes that the State has a moral obligation to provide for prisoners' basic needs, when their liberty has been taken away.

Appendix A

CALIFORNIA COUNCIL OF CHURCHES

Amicus Curiae California Council of Churches is an organization whose membership comprises more than 4,000 of California's Christian congregations from 51 denominations, including both mainstream and progressive Protestant and Orthodox Christian communities. The Council advocates for social justice on behalf of its member congregations and denominations, many of which maintain active prison ministries in California and all of which support the view that prisoners, like all others created in the image of God, deserve humane treatment, decent conditions of incarceration, and an opportunity to seek redemption through religion.

FRIENDS COMMITTEE ON LEGISLATION OF CALIFORNIA

Amicus Curiae Friends Committee on Legislation of California (FCLCA) is a statewide advocacy organization founded in 1952 by Members of the Religious Society of Friends. Guided by Quaker values and the belief that God inheres in every person, FCLCA advocates for California laws that are just, compassionate, and respectful of the worth of every person. Friends have a historical commitment to prison reform, and FCLCA counts California prisoners and their families among our constituencies, providing them with information and education on California politics. Through our advocacy and our prior participation in the Statewide Advisory Council on Institutional Religion, FCLCA is keenly aware of the detrimental effects prison overcrowding has on rehabilitative programming and religious services and has advocated for alternatives to incarceration for persons convicted of low-level offenses. To reduce prison violence, FCLCA took a lead role in expanding into more California prisons the Alternatives to Violence Project, a collaboration between Quakers and prisoners that has been embraced by the California Department of Corrections and Rehabilitation.

GENERAL SYNOD OF THE UNITED CHURCH OF CHRIST

Amicus Curiae General Synod of the United Church of Christ is the representative body of the national setting of the United Church of Christ (UCC) and is composed of delegates chosen by its Conferences, from member churches, voting members of Boards of Directors of Covenanted Ministries who have been elected by General Synod as described in the Bylaws of the UCC, and of ex officio delegates. The UCC was formed in 1957, by the union of the Evangelical and Reformed Church and The General Council of the Congregational Christian Churches of the United States in order to express more fully the oneness in Christ of the churches composing it, to make more effective their common witness in Christ, and to serve God's people in the world. The UCC has 5,600 churches in the United States, with a membership of approximately 1.2 million. The General Synod of the UCC, various settings of the UCC, and its predecessor denominations, have a rich heritage of standing in solidarity with those who are marginalized, oppressed, and who suffer under the tyranny of injustice. At its tenth and eleventh gatherings, the General Synod sought to emphasize the involvement of the United Church of Christ in a national campaign to promote progressive changes in the American Criminal Justice and Penal Systems, and at its twenty-first gathering the General Synod passed a resolution advocating in part for caps on prison populations.

ISLAMIC SHURA COUNCIL OF SOUTHERN CALIFORNIA

Amicus Curiae Islamic Shura Council of Southern California is an umbrella organization of Mosques and Muslim organizations and it assists its member organizations in serving the Muslim community and the society-at-large. It represents the consensus of its members and coordinates community activities, enables effective communications, advocates on behalf of its member organizations, and fosters leadership development. Shura Council's Executive Director, Shakeel Syed, has been serving California state and federal institutions as a volunteer chaplain for more than two decades.

LEADERSHIP CONFERENCE OF WOMEN RELIGIOUS

Amicus Curiae Leadership Conference of Women Religious (LCWR) is a membership organization of leaders of Catholic women religious in the United States, whose members represent more than ninety percent of the 59,000 Catholic sisters in this country. The core mission of the LCWR and our members is to further the Gospel in today's world. The LCWR has a long history of active concern for human life and dignity. Jesus himself was an abused prisoner, and in his description of the Last Judgment, he identifies himself with all who suffer, including prisoners: "I was ill and you comforted me, in prison and you came to visit me." *Matthew* 25:36. Some LCWR members are residents of California; some sisters across the country are engaged in prison ministry; and many of our members are involved in Catholic health care ministry. While overcrowding in prisons across the country leads to illness and avoidable deaths, conditions in California prisons are particularly appalling. We hold in prayer all prisoners and guards held hostage by the "state of emergency" articulated by Governor Schwarzenegger.

NATIONAL ASSOCIATION OF EVANGELICALS

Amicus Curiae National Association of Evangelicals (NAE) is the largest network of evangelical churches, denominations, colleges, and independent ministries in the United States. It serves 50 member denominations and associations, representing 45,000 local churches and millions of Christians. The NAE serves as the collective voice of evangelical churches and other religious ministries, which engage in prison visitation and service ministries following the direct teachings of Scripture to "remember those in prison as if you were their fellow prisoners." *Hebrews* 13:3; *see also Matthew* 25:36. The

NAE believes that religious freedom is a gift from God that the government does not create but is charged to protect for all persons including prisoners. NAE recognizes imprisoned believers as the "church-behind-the-walls," which should enjoy the same religious freedoms and protections as those on the outside. The NAE also believes that the Christian message of faith, forgiveness, and hope is the most powerful force for the rehabilitation of those who are behind bars as they prepare to reenter society, and that it is therefore critical for prison systems to make adequate provision for the free exercise of religion by all prisoners.

NATIONAL COUNCIL OF CHURCHES

The National Council of Churches, also known as the National Council of the Churches of Christ in the USA, is a community of 35 Protestant, Anglican, Orthodox, historic African-American, and Living Peace member faith groups, which include 45 million persons in more than 100,000 local congregations in communities across the nation. Its positions on public issues are taken on the basis of policies developed by its General Assembly. The National Council of Churches is a member of the coalition that helped create RLUIPA, in part to protect the rights of institutionalized persons to access religious and spiritual services and to address religious discrimination experienced both by member communions and other religious groups.

Appendix A

PAULIST NATIONAL CATHOLIC EVANGELIZATION ASSOCIATION

Amicus Curiae Paulist National Catholic Evangelization Association (the Association), through its Prison Ministry (the Ministry), provides religious material for Catholics incarcerated in federal, state, and county prisons. The Ministry supports prisoners in pursuing spiritual and personal growth under difficult circumstances and helps them preserve their Catholic faith and seek redemption and salvation. The Ministry is almost two decades old. It sends newsletters quarterly to more than 500 prison chaplains for distribution to prisoners, delivers thousands of Bibles to prisoners through Catholic chaplains, and provides a book on the Catholic faith so prisoners can grow in their understanding. The Association is a non-profit apostolic arm of the Paulist Fathers, a national missionary community of Catholic priests.

PROGRESSIVE JEWISH ALLIANCE

Amicus Curiae Progressive Jewish Alliance (PJA) is a non-profit, California-based membership organization, with more than 4,000 members, which educates, advocates, and organizes on issues of peace, equality, diversity, and justice. Founded in 1999 and with offices in Los Angeles and the San Francisco Bay Area, PJA serves as a vehicle connecting Jews to the critical social justice issues of the day, to the life of the cities in which they live, and to the Jewish tradition of working for *tikkun olam* (the repair of the world). PJA's work, which has included restorative justice, is inspired by the Jewish ethical tradition and is grounded in modern democratic principles. The Jewish tradition gives great weight to the importance of *teshuva* (to turn away from wrongdoing) and *cheshbon ha' nefsh* (attention to matters of ethics). Therefore, the opportunities provided by the correction system for rehabilitation, spiritual reflection, and religious dedication are of great importance to the members of PJA. PJA's institutional support for humane criminal justice policies and our commitment to the Eighth Amendment prohibition of cruel and unusual punishment also counsel concern for the conditions of incarceration and treatment of prisoners by the State.

SOJOURNERS

Amicus Curiae Sojourners is an organization whose mission is to articulate the Biblical call to social justice. An essential grounding for that call is the deeply held belief in the dignity of each human being created in the image of God. We advocate for greater justice for prisoners in our work in Washington, D.C.; provide copies of *Sojourners* magazine to prisoners; and have participated in providing resources and speakers for prison-based theological studies programs. We believe prisoners have a fundamental human and constitutional right to conditions that are humane and that allow them to freely exercise their religion.

Appendix A

UNION FOR REFORM JUDAISM

Amicus Curiae Union for Reform Judaism is the congregational arm of the Reform Movement in North America, including 900 congregations encompassing 1.5 million Reform Jews. We come to this issue inspired by the words of *Deuteronomy* 16:20, in which the Torah commands us, *Tzedek, tzedek tirdof,* "Justice, justice you shall pursue." The sages explained that the word (*tzedek*) is repeated not only for emphasis but to teach us that we must be just in our pursuit of justice, that our means must be as just as our ends. As such, we are concerned with the consequences of some forms of treatment for prisoners within the criminal justice system, including ensuring that inmates receive proper medical treatment.

UNITARIAN UNIVERSALIST ASSOCIATION

The Unitarian Universalist Association is a religious association of more than 1,000 congregations in the United States and North America. Through its democratic process, the Association adopts resolutions consistent with its fundamental principles and purposes. In particular, the Association adopted in 2005 a Statement of Conscience entitled "Criminal Justice and Prison Reform" based upon its fundamental principle of the inherent worth and dignity of every person. The Statement of Conscience deplores the violation of basic human rights in some prisons and calls for a new corrections policy in the United States. The Statement of Conscience also calls for the establishment of Unitarian Universalist prison ministries by local congregations.